

SIMON FRASER UNIVERSITY

**“GIVING A HAND TO
DISPLACED BURMESE
LIVING WITH HIV/AIDS”**

FINAL REPORT

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MAE SOT, THAILAND

“Giving a Hand to Displaced Burmese Living With HIV/AIDS”

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Canadian AIDS Treatment
Information Exchange

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FOREWORD

People living with HIV/AIDS around the world often encounter difficulty in receiving the health care they need due to political, economic, and socio-cultural constraints. In the community of people from Burma along the Thai-Burma border, this is particularly true given the instability of the environment in which they reside. Being illegally present, living in poverty, and experiencing social discrimination only exacerbate the struggle to access available health services. Ultimately, this limitation of access to their right to health creates a vicious cycle in which it negatively affects the already low quality of that many people living here endure. This unfortunate situation is aggravated in the case of people living with HIV/AIDS because of the chronic nature of their illness.

Mae Tao Clinic is a community-based organization serving Burmese migrants and refugee patients along the Thai-Burma border to obtain health services. Our clinic aims not only to attend to their medical needs but also to function as a regional training center for community health workers in order to help build capacity among these communities. The Clinic's staff, patients, and trainees represent a diverse ethnic makeup with varying religious and political affiliations. Our clinic's philosophy aims to encounter discriminatory practices and endeavor to foster inclusiveness and understanding among diversity.

HIV/AIDS has been a major health concern and a core issue at the Clinic over the last two decades. Routine services such as Voluntary Counseling and Testing (VCT) for antenatal care patients, potential blood donors, and any individual who requests testing have been provided free of charge by the Clinic. Health education on prevention is promoted through our outreach services such as the blood donation and adolescent reproductive health programs, as well as through inclusion in our health worker training curricula. For people living with HIV/AIDS, the services provided free of charge include:

- Inpatient admission care
- Home-based care including supplementary dry food rations and support group counseling
- Prevention of opportunistic infections through health education and condom distribution
- Treatment of opportunistic infections identified through follow-up visit
- Collaboration with Mae Sot Hospital for the prevention of mother to child transmission (PMTCT) and anti-retroviral (ARV) treatment

To add to these services and programs, Dr. Thiha Maung Maung from Simon Fraser University has graciously invested in the Clinic with training sessions and health education materials during his visit in August of 2008. The training sessions provided further understanding of selected HIV-related topics for the Clinic's staff and peer counselors for home-based care. The pamphlets are useful for broadening the scope of the health education program by addressing the issue of self-coping skills when affected by HIV/AIDS. The results of the research project conducted on the Thai-Burma border will certainly support our work by identifying the health and knowledge needs of the Burmese migrant people living with HIV/AIDS and foster a more thorough understanding of the difficulties experienced by this community.

"This work was carried out with the aid of a grant from the International Development Research Centre, Ottawa, Canada."

Our appreciation is extended to those who helped implement this project, with particular thanks to Simon Fraser University, the British Columbia Centre for Excellence in HIV/AIDS, and the International Development Research Centre (IDRC). Mae Tao Clinic strives to improve its capacity for care and support of Burmese people living with HIV/AIDS, and we look forward to additional collaborative projects in future.

Sincerely,

A handwritten signature in black ink, consisting of a large, stylized 'C' followed by a horizontal line and a small flourish.

Dr. Cynthia Maung,
Director, Mae Tao Clinic

FOREWORD

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), more than 33 million people are living with HIV/AIDS in 2008 and of these people 95 per cent are living in low and medium income countries. In Burma, the UNAIDS estimates that 200,000 to 570,000 adults are infected with HIV. Of these people, the MSF estimates that 25,000 died in 2007 from causes that could have been prevented with the use of antiretrovirals. The lack of access to HIV care and antiretroviral therapy is especially noticeable among the Burmese HIV-positive refugees that now live in Thailand.

Dr. Thiha Maung Maung, a graduate student from the Faculty of Health Sciences at Simon Fraser University, provides important insights into the health status and access to care issue for HIV-positive Burma refugees in Thailand. As a physician that once treated HIV positive people in Burma he is well aware of their treatment needs. His work demonstrates that given current cultural barriers in Thailand and the inability of these refugees' to access the host country's health system, the treatment of HIV infection among displaced Burmese living with HIV in Thailand is very problematic.

I would like to congratulate Dr. Thiha Maung Maung on his hard work and determination. This important manuscript will hopefully allow him and others to lobby for the needs of displaced Burmese living with HIV in Thailand. I would also like to acknowledge the assistance of the LISA staff on this project and the support of Dr. Michel Joffres, Director of Graduate Studies at the Faculty of Health Sciences, Simon Fraser University and Dr. Julio Montaner's, the President of International AIDS Society and Director of the B.C. Centre for Excellence in HIV/AIDS. Without their support and assistance this project could not have been implemented successfully.

I hope that research findings from this project will help to provide additional resources to displaced HIV-positive Burmese refugees in Thailand and will guide future HIV prevention and care projects of this type in Thailand and elsewhere.

Sincerely,

Dr. Robert Hogg
Professor, Faculty of Health Sciences, Simon Fraser University
Director, Drug and Treatment Program, British Columbia Centre for Excellence in HIV/AIDS

ACKNOWLEDGEMENT

Displaced Burmese with HIV/AIDS are living in difficult conditions within Thailand. They struggle daily with economic and social problems, as well as barriers to accessing adequate health care. The Canadian International Development Research Center (IDRC) has helped to address the problems this community faces by granting me the required funding to implement this health project, which will hopefully bring assistance to the displaced Burmese living with HIV/AIDS in Thailand.

Dr. Robert Hogg, Director of the Drug Treatment Program at the British Columbia Centre for Excellence in HIV/AIDS and Dr. John Farley, an Infectious Diseases Specialist from British Columbia, Canada, directed this project to ensure its objective was effectively achieved. Their guidance and supervision led to the efficient and successful completion of this project. Eirikka Brandson, Alexis K. Palmer and Wendy Zhang, from the British Columbia Centre for Excellence in HIV/AIDS, developed research questionnaires and analyzed the research data with great expertise and knowledge. The selfless dedication of researchers at the British Columbia Centre for Excellence in HIV/AIDS toward those who are in great need is immense. They have exemplified the *'Canadian spirit'* of extending a hand to those in need of assistance.

To increase HIV/AIDS-related knowledge for Displaced Burmese with HIV/AIDS, the British Columbia Persons with AIDS (BCPWA) Society and the Canadian AIDS Treatment Information Exchange (CATIE) allowed me to translate their educational pamphlets. Zoran Stjepanovic, Treatment Information Coordinator at BCPWA, enthusiastically helped to develop pamphlets and training modules for HIV/AIDS counselors and displaced Burmese living with HIV/AIDS in Thailand. Their help made the acquisition of up-to-date and relevant HIV/AIDS-related information possible.

Special mention need also be made to the following MPH-Global Health candidates at Simon Fraser University: Autumn Mochinski, Sirad Deria, Stephanie Gatto, Eliza Seaborn, Maya Nakajima and Helen Hsu, evaluation analyst from the British Columbia Centre for Disease Control (BC CDC). Their keen interest and desire to provide editing assistance enabled the timely completion and professional presentation of this report. I would like to extend my appreciation for their patience, determination, and most importantly for believing and supporting in the cause of this project.

In addition, I would like to express my deep gratitude to Dr. Michel Joffres, Director of Graduate Studies, Ellen Loosley, Office of Research Services Director, Dr. Edward J. Mills and all other faculty members at the Faculty of Health Sciences (FHS) at Simon Fraser University, who contributed their time towards the accomplishment of this project. I must confess that community consultation events in Thailand would not have been accomplished without the proper guidance of Dr. Malcolm Steinberg from the FHS. I profoundly appreciate all the time and effort they applied for the successful implementation of this project.

Finally, the success of this project was made possible by the close supervision of Dr. Cynthia Maung, director of Mae Tao Clinic as well as by the active involvement of the staff and the medical volunteers at Mae Tao Clinic. They have been continuously helping displaced Burmese living with HIV/AIDS in Thailand for many years and have contributed to the improvement of thousands of lives. I would like to extend my heartfelt gratitude to all those who have given a helping hand to the displaced Burmese living with HIV/AIDS.

Yours truly,

Dr. Thiha Maung Maung
Project Implementer

INTRODUCTION

"When Myanmar (Burma) joined ASEAN in 1997, there were only 210,000 Burmese refugees and asylum seekers throughout the region. Now, nearly 1 million people have fled Myanmar's political and economic chaos for neighboring countries, and another million people remain internally displaced."

Thai Senator Hon. Jon Ungphakorn in October, 2005^[8]

Thailand is often considered a land of opportunity for many Burmese people living in economic and political oppression in Burma (Myanmar). For this reason, the Thai-Burma border witnesses a steady influx of Burmese migrants seeking refuge and new beginnings in neighboring Thailand.^[1, 17, 23]

Burma (Myanmar) has been ruled by self-appointed military-led governments for nearly half a century. Under military dictatorship, this country, which used to be rich in natural and man-made resources, has become one of the poorest in the world^[9] with deteriorating health and education systems. In 2000, the World Health Organization ranked the health system of Burma as 190th out of 191 nations, outperforming only war-torn Sierra Leone.^[63]

The medical and education shortfalls of Burma (Myanmar) have been exacerbated by military junta policies which have impoverished the country.^[1, 9] For several decades, the incomes of a quarter of all Burmese households have been below the minimal subsistence level, and 70% of household expenditures are being spent on food.^[8] As a result, basic education and health services have been inaccessible for most Burmese; this lack of access has been even more pronounced in rural areas where poverty is more prevalent.^[8] Traditionally, Burmese culture has placed a high value on education. While early school enrolment rates at the elementary school level have been high at over 80% for both boys and girls, the drop-out rate has also been high with less than 55% of children actually completing the primary cycle.^[57]

The military regime has long overlooked the public health and education systems, and this has posed a threat to the wellbeing of the citizens of this impoverished country. The government spends more on military expenses than on public health care.^[8] Indeed, the Burmese government's spending on its public health care system is one of the lowest in the world. In 2008, the government's health care spending on Burmese citizens was 0.70 U.S. Dollar (USD) per person.^[30] An example of how the lack of investment in health has been detrimental to the health status of the population is illustrated by Burma's underdeveloped HIV surveillance system and its limited dissemination of health information on HIV/AIDS to the public; these shortfalls have in turn greatly increased the population's risk of contracting HIV. By 2000, Burma (Myanmar) clearly had a generalized HIV epidemic with an estimated 1/29 adults living with the virus.^[8] In 2006, Burma (Myanmar) was identified as one of 22 countries which accounted for 80% of the world's new HIV cases, with approximately 97,000 individuals becoming newly infected each year.^[8] The elevated incidence and prevalence of HIV has become a significant concern and has put vulnerable populations in Burma (Myanmar) at an increased risk for infection.^[54]

Despite their knowledge of the HIV epidemic, the Burmese military junta has yet to publicly admit that the health of Burmese citizens was ever in jeopardy. Denial has become the typical response of the Burmese military regime.^[43] The junta fabricates news in the media and declares that western countries are attempting to control Burma via neo-colonial strategies.^[35] when in fact, the junta rules Burma ruthlessly, oftentimes violating the human rights of its own citizens. To date, Aung San Suu Kyi (2007 Honorary Canadian citizenship winner), a Burmese leader who was democratically elected by a landslide victory in the 1990's, remains the only Nobel Peace Prize winner currently in detention. In addition, many Burmese students and human rights activists are in prison in the name of political instability, and Burmese citizens continue to suffer from the consequences of the junta's long-term mismanagement.

In late 2006, the USA and the UK sent a draft resolution to the United Nations Security Council on the issue of Burma (Myanmar) members, calling on the junta controlling Burma (Myanmar) to release all political prisoners, to initiate widespread dialogue and to end its military attacks and human rights abuses against ethnic minorities.^[22] The draft received 9 votes in favor of this resolution but was vetoed by China, Russia and South Africa. As a result, the resolution failed.^[22]

The military-led government's economic mismanagement, human rights abuses and high currency inflation rate were the principal causes of the 2007 "Saffron Revolution", in which thousands of monks and Burmese citizens around the country took to the streets in a number of Burmese towns to protest and demand for lower basic commodity prices.^[9] As predicted, the junta repressed the protests violently, killing hundreds of people and arresting many more.

Burmese people have consequently been subjected to increased oppression and various human rights abuses. Under the current situation in Burma (Myanmar), higher numbers of Burmese people are relocating to neighboring Thailand. Currently, Burma (Myanmar) has become a source country for trafficking men, women, and children in East and Southeast Asia, resulting in sexual exploitation, domestic service, and forced commercial labor.^[9] These numbers continue to grow daily as a result of ongoing human rights violations by Burma's ruling military junta and also due to the desperate economic conditions in Burma.^[16, 71]

There are four different kinds of Burmese migrants in Thailand:

1. **Registered migrants** are those whom the Royal Thai government has granted working permits in Thailand; it is estimated that registered Burmese migrants represent less than 10% of the total Burmese migrant population in Thailand.
2. **Unregistered (illegal) migrant population**; these constitute the majority (more than 90%) of Burmese in Thailand. Here, they live and work in Thailand without any official documentation.
3. **Cross border population**; these migrants come to Thailand temporarily for a day or two's work and return to their place of residence in Burma.
4. **Refugees** are those who have been granted refugee status by the United Nations High Commissioners for Refugees and live in refugee camps.

Burmese migrants in Thailand encounter economic hardships as they are paid far less than the minimum wage set by the Thai authorities.^[23, 29] They are often employed at very low wages in the manufacturing, agricultural, construction, and sex industries. Most of the men work as factory workers, on rubber plantations or in construction; the women often work as sex workers, cleaners or waitresses.^[29] The future of these migrants is uncertain as they face the risk of arrest and deportation at anytime. They live in inhumane and unhealthy conditions and, normally, they do not receive social and/or cultural support.^[17]

Burmese migrants often face serious obstacles to optimal health outcomes due to discrimination, language and cultural barriers, illegal status and other economic and social difficulties.^[37] Without legal immigration status, Burmese migrants cannot receive medical insurance, and without this, they are denied even basic healthcare.^[29] In response to these issues, the Thai Ministry of Public Health is attempting to establish health insurance for registered Burmese migrants.

However, only a small fraction (about 500, 000 Burmese) have registered in Thailand; this is estimated to be about 2% of the Burmese migrant population residing in Thailand.^[40] Even Burmese migrants with legal status often die from untreated, often harmless diseases; this is because they are often afraid of facing the authorities if they visit a hospital and because they do not understand enough of the language to realize that they are actually entitled to healthcare.^[29] It is therefore apparent that this process has not benefited the majority of Burmese migrants

despite it being a necessary step in improving health outcomes and addressing the major health problems, such as infectious diseases, among displaced Burmese. Sadly, many risk factors that are known to facilitate HIV/AIDS transmission are especially prevalent in the Thai-Burma border region where most of the unregistered displaced Burmese reside.^[17]

Drug-related crime, sexual abuse and human trafficking activities are concentrated on the Thai-Burma border. As a result of an inadequate health education system, general knowledge of HIV/AIDS is very limited.^[45, 71] Although the number of annual HIV infections in Thailand has declined, these risk factors put vulnerable groups at an increased risk for infectious diseases, including HIV/AIDS.^[54] Between April 2003 and March 2005, 20% of Burmese migrants who received voluntary counseling and testing services at the Thai-Burma border were found to be HIV-positive.^[60] The Mae Tao Clinic, the principal health centre for Burmese migrants in Thailand, continues to provide voluntary counseling and testing for HIV services. In 2007 alone, 17.9 % of those who received voluntary testing were found to be HIV positive.^[25]

Displaced Burmese people living with HIV/AIDS in Thailand are faced with terrible circumstances and are severely socially marginalized. One of the challenges they face is living in makeshift housing with no electricity, running water, or sanitary facilities.^[25] Health care and support for HIV/AIDS require more complex and long-term services than many other diseases. This puts a disproportionately heavy strain on migrant health care services in the Thai-Burma border area.^[24, 26] Needless to say, better prevention and intervention efforts are urgently needed to help displaced Burmese with HIV/AIDS. It is essential that we act now to assist and enable this population to cope with their daily challenges and to also strive to discover more effective and sustainable ways of providing treatment, care and support for the displaced Burmese with HIV/AIDS.

Aim

"To help displaced Burmese living with HIV/AIDS in Thailand"

Objectives

1. To provide training in opportunistic infection control and health monitoring for people living with HIV/AIDS and for HIV/AIDS caregivers on the Thai-Burma border
2. To distribute HIV/AIDS education pamphlets translated into Burmese on the Thai-Burma border
3. To conduct health-related quality of life (HR-QoL) assessment research on displaced Burmese living with HIV/AIDS on the Thai-Burma border

Monitoring and Evaluation

The British Columbia Persons with AIDS (BCPWA) Society is dedicated to empowering people living with HIV/AIDS. It is the largest AIDS organization in Western Canada, providing training and HIV education for British Columbians living with HIV/AIDS. Training materials and HIV health education pamphlets were directly translated into Burmese from existing BCPWA materials with approval from BCPWA Society's Board of Directors.

Dr. Cynthia Maung and other international physicians are providing clinical care for displaced Burmese at the Mae Tao clinic. Training for healthcare workers and distribution of pamphlets in the border area were monitored directly by the Mae Tao clinic. Some sections of the pamphlets were directly translated from existing Canadian AIDS Treatment Information Exchange (CATIE) materials. CATIE had also agreed to have their materials translated into Burmese.

Health related quality of life (HR-QoL) assessment research for displaced Burmese living with HIV/AIDS was supervised by Dr. Robert Hogg, a professor in the Faculty of Health Sciences at Simon Fraser University and the director of the Drug Treatment Program at the BC Centre for Excellence in HIV/AIDS and Dr. John Farley, an infectious diseases specialist in HIV and Hepatitis C infections. Researchers at the British Columbia Centre for Excellence in HIV/AIDS, faculty members from the Faculty of Health Sciences at Simon Fraser University and clinicians from the Mae Tao clinic actively monitored and contributed their time to get precise study results.

HIV/AIDS SITUATION IN BURMA

"Myanmar is experiencing one of Asia's most serious HIV epidemics, yet the available care and treatment meet only a fraction of the needs. As a result people are dying unnecessarily, people who are desperate to live and contribute to their family, community and country."

Medecins Sans Frontieres (MSF) Report, 2008.^[30]

The first HIV case in Burma (Myanmar) was reported in 1988 and the first AIDS patient in 1991.^[49] In the initial phases, HIV had a stronghold over certain communities, notably among Burmese intravenous drug-users.^[10] Burma (Myanmar) is the world's second largest producer of illicit opium.^[9] The Golden Triangle — the north-east corner of Burma (Myanmar), bordering Laos, China and Thailand — is infamous for being a key heroin producing area.^[20] Burma is at the heart of the "golden triangle" of poppy farming and as such, opiate use has long been common there. Of great concern was the fact that most intravenous drug users share needles which often results in increased HIV transmission; needle-sharing continues to be prevalent among Burmese intravenous drug users and has been since the early days of the HIV epidemic.

In 1994, the World Health Organization (WHO) reported that 60 to 70 per cent of all intravenous drug-users in Burma (Myanmar) were HIV-positive, representing the highest HIV infection rate among drug users in the world.^[6, 10] In response to the increased HIV transmission rates, the government confined intravenous drug users to jail. In 1989, 96% of injection drug users in the notorious Bahmo prison were found to be HIV-positive based on testing.^[48] Moreover, Myanmar's military junta is reputed internationally as a government of concealment and it has been criticized for neglecting to address the spread of HIV and for underreporting HIV/AIDS epidemic figures.^[70]

With the mishandling of the epidemic, HIV/AIDS among drug users became a threat to all Burmese. Through sexual contact, HIV was transmitted from intravenous drug users to members of the general public. At this time, an alarming rate of HIV infection among prostitutes, people with venereal diseases, and pregnant women suggested that heterosexual transmission of HIV was a major problem.

"The cultural and social values of Myanmar society are found to have a protective effect to a greater extent than in many population groups"

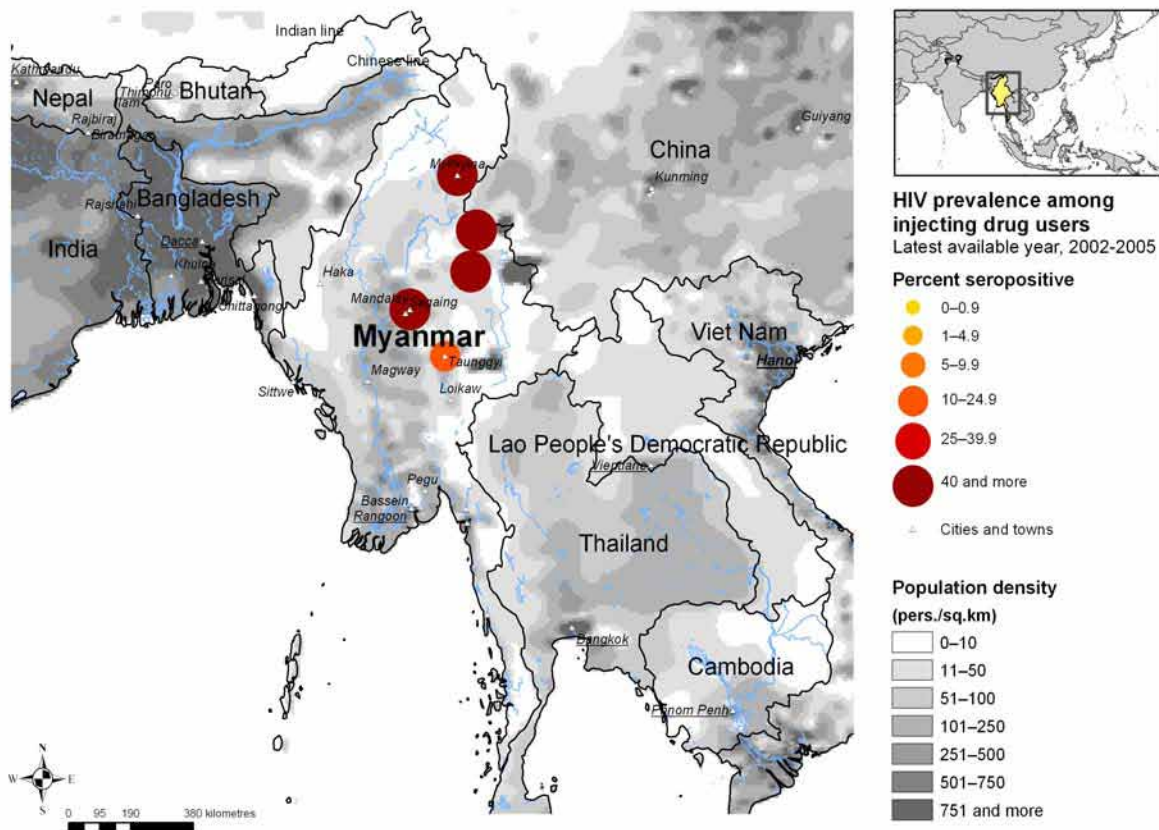
General Khin Nyunt on World AIDS Day in December, 2003.^[43]

Although the domestic commercial sex industry fueled the transmission of HIV, the Burmese government denied the possibility that sexual activity and commercial sex were common in a Buddhist society like Burma (Myanmar).^[43] The junta stated that Burmese culture stressed abstinence before marriage and fidelity following marriage. However, the strain of HIV prevalence in Burma (Myanmar) was similar to that found in neighboring Thailand, pointing to the possible spread of HIV through sexual contact.^[73] In 1995, The World Health Organization (WHO) estimated that half a million people in the country were infected with HIV.^[10]

Despite a large number of AIDS cases, Burma (Myanmar) had only two hospitals with AIDS wards by 1999.^[43] Even in central reference laboratories, there were no facilities to test CD4 counts which are an essential method of evaluating the immune systems of infected individuals.^[8] Testing of CD4 counts is also considered to be part of the basic care and monitoring of HIV patients. The Burmese junta spends more of the country's earnings, wealth from natural resources, to bolster the over 400,000-strong army than it does on the healthcare for its population of 54 million people.^[8] In such an impoverished country, only a handful of citizens have the capacity to afford the relatively expensive antiretroviral medications necessary to prevent the progression of the virus.^[30] Indeed, the health care system in Burma was so deficient

that the World Health Organization ranked Burma (Myanmar) 190 out of 191 member countries in 2000, only above war-torn Sierra Leone.^[63] In 2000, the Burmese junta announced that HIV prevalence in Burma was 0.94%.^[33] In 2001, the United States Agency for International Development (USAID) estimated that 2-3.5% of Burmese were living with HIV.^[59]

The military-led Burmese government tightly controls the dissemination of information. As such, it is difficult to obtain accurate HIV/AIDS figures. However, in 2001, the United Nations Joint Program for HIV/AIDS (UNAIDS) estimated that 400,000 Burmese were infected with HIV. Finally in 2002, the military government halted its denial of the HIV epidemic and attempted to control the spread of HIV in Burma.^[43] However, by that time, deep poverty, sex trade work and drug use problems had all further accelerated the transmission of HIV and many young Burmese had died of AIDS without having any knowledge of the disease that killed them.^[30]



Map 1 - HIV prevalence among injection drug users in Burma (source: WHO)^[66]

The Burmese government had undertaken a few measures to control the HIV epidemic. However, widespread corruption at every level of the current governmental structure makes it increasingly difficult for the planning and implementation of effective preventive measures against the epidemic.^[8, 47] The military junta maintains a suspicious eye on international donors and NGOs, claiming they are involved with opposition party propaganda on human rights issues. Military authorities have banned foreign NGOs from taking part in work that takes them outside of their offices - preventing them from delivering food aid to thousands of HIV/AIDS patients and making it impossible to continue necessary outreach programs, such as those that promote safe sex and the use of clean needles. Even worse, the junta has set unnecessary limitations for foreign NGOs which have the capacity to handle effective preventive measures against HIV/AIDS.^[47] Western donors have become very frustrated by the junta's limitations. For instance, foreign NGO staff who were responsible for HIV/AIDS care and preventive measures in

Burma (Myanmar) were, and still are, faced with travel clearance procedural barriers which restrict their access. Thus, NGO staff lack the freedom to be mobile in particular areas and communities; this in turn poses a major impediment to implementing and scaling up HIV/AIDS interventions where they are most needed.^[53]

In August, 2005, The Global Fund terminated a 98.4 million US dollar grant to Burma (Myanmar). The Global Fund stated that, "Given new restrictions recently imposed by the government which contravene earlier written assurances it has provided the Global Fund, the Global Fund has now concluded that the grants cannot be implemented in a way that ensures effective program implementation. After discussions with UNDP, the Global Fund has decided to terminate the grant agreements that were effective August 18th, 2005."^[47] It was the first time in history that The Global Fund had cancelled grant funding. Despite the negative impact of their policies, the junta set more restrictions on international donors, NGOs and international engagement in Burma in February, 2006.^[8] As a result, some Medecins Sans Frontiers (MSF) and International Red Cross (IRC) offices closed down.

The junta's restriction on international aid has been inhumane in many ways. For example, in May 2, 2008, cyclone Nargis hit the delta region of Burma (Myanmar), killing more than 100, 000 people.^[38] The junta blocked large-scale foreign assistance to help the cyclone survivors, and resisted foreign pressure and UN secretary general Ban Ki-moon's request that they permit foreign help.^[38] The junta stated that, "Burmese people from the cyclone hit area can survive on their own, even without bars of chocolate donated by the international community; they could eat frogs."^[38]

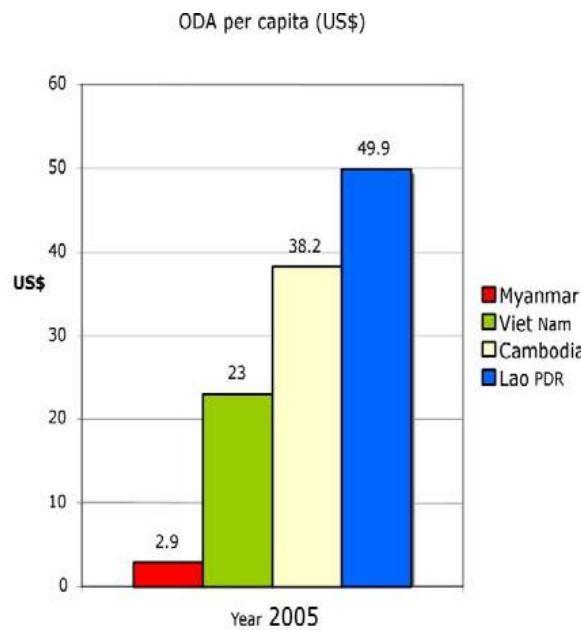


Figure 1 - Overseas Development Assistance (ODA) funding per capita in selected Asian Countries: *source MSF 2008.*^[30]

Military led government policies which restrict public health, humanitarian aid and lack international support have created favorable grounds for HIV/AIDS to spread freely. Burmese generals often claim that the current HIV/AIDS care and prevention operations are running very well.^[33, 49] In reality, the junta is encountering complex challenges to HIV prevention and care efforts, and they are facing a severe epidemic of HIV/AIDS. WHO stated that "With a national

estimated prevalence of between 0.6% and 2.2%, Myanmar is experiencing a generalized epidemic; this very serious epidemic may grow out of control unless an effective coordinated response is urgently implemented."^[64]

Public hospitals in Burma (Myanmar) are continually in short supply of therapeutic drugs and Burmese people are unable to afford expensive anti-retroviral (ARV) medications.^[30] For most individuals, treatment options in Burma (Myanmar) are almost non-existent and prevention efforts comprise the major health care initiatives against the HIV epidemic. UNAIDS has helped to provide free ARV support to Burmese people; however, in 2005 only 3% of people with HIV/AIDS who were in need of treatment were receiving ARV.^[64] As international support for Burma (Myanmar) continues to decline, even the future of those Burmese people who currently have access to ARV is uncertain.

"People affected by HIV/AIDS in Myanmar are desperate for more assistance. They want to live healthy and happy lives like any other. The ground-swell is there – HIV patient groups are forming around the country and our medical staff works tirelessly to assist patients. But it is just not enough, the problem is too big. Others must do more."

Medecins Sans Frontieres National Staff MSF Report, 2008.^[30]

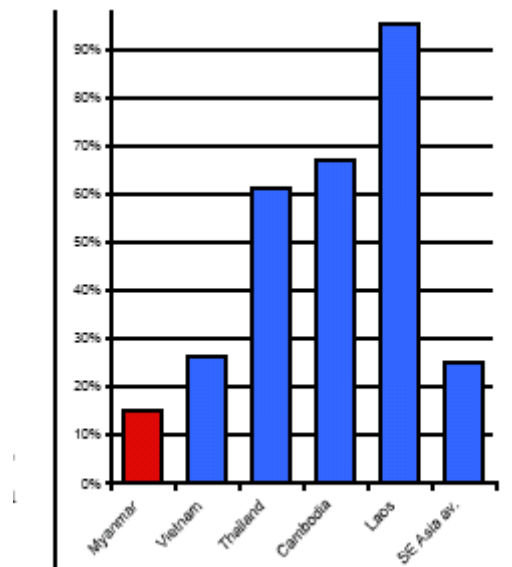


Figure 2 - Anti Retro Viral Therapy (ART) coverage (percentage) end 2007, Comparison with nearby countries: *source MSF 2008.*^[30]

A major problem is that the Burmese military government spends about 70 cents per citizen^[69] on health care annually and most people cannot afford the cheapest antiretroviral regimens, which costs about \$30 monthly^[30] from private physicians. Burma's Ministry of Health has frequently reported that more action is being undertaken against the HIV epidemic in terms of care and support and that overall, the country's HIV prevalence rate is declining.^[33]

In 2007, UNAIDS reported that the prevalence of HIV among high risk populations is elevating in Burma.^[54] Such an increase in HIV prevalence poses a major concern for neighboring countries and the international community. The generalized HIV/AIDS epidemic in Burma (Myanmar) is one of the most serious in Asia, and the national prevalence is close to that of Cambodia and Thailand.^[64] However, the Burmese junta released a report indicating a

different estimation of the HIV epidemic. They reported that, "National HIV prevalence rate is 0.67% in 2007; dramatic decline in prevalence curve is due to government, international and nation NGOs' well coordinated response."^[33, 41] Nevertheless, true estimates of the HIV/AIDS burden in Burma (Myanmar) remain unclear.

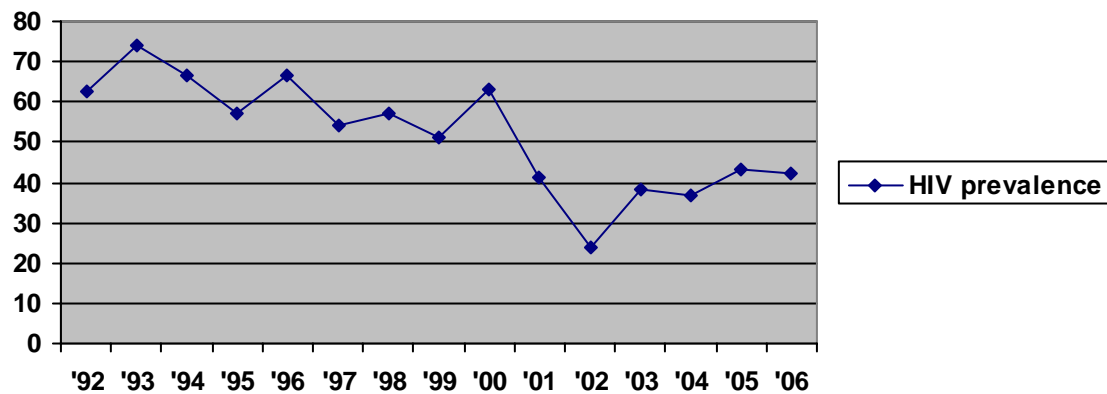


Figure 3 - Burmese Department of Health Reported HIV prevalence (percentage) among injecting drug users. (Source: National AIDS Programme and Ministry of Health, Myanmar)^[41]

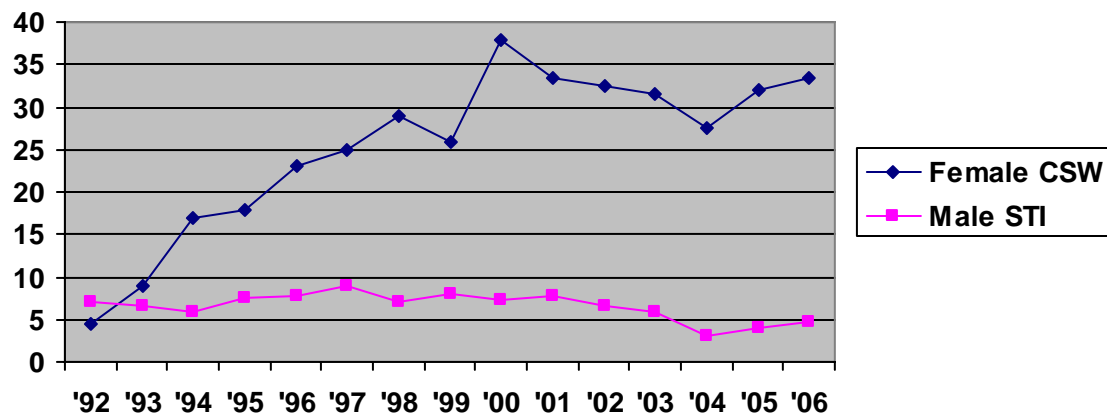


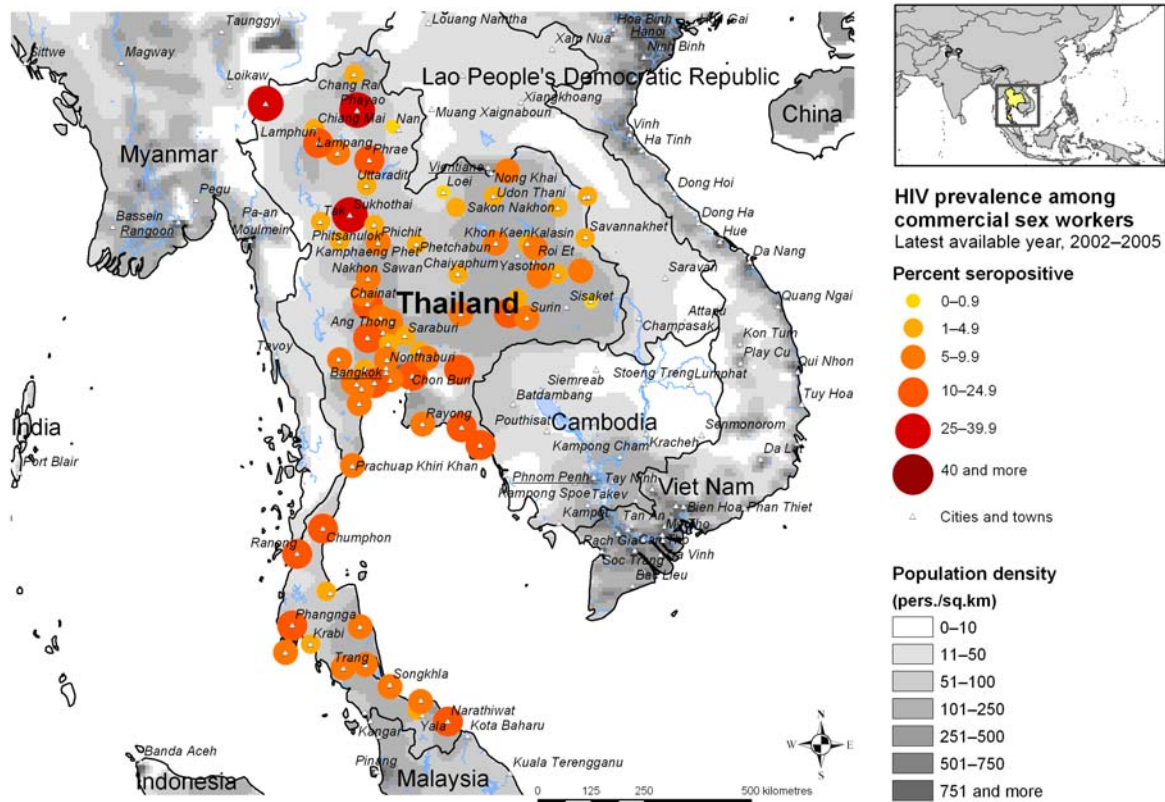
Figure 4 - Burmese Department of Health Reported HIV prevalence(percentage) among female commercial sex workers (Female CSW) and male patients with sexually transmitted infections (Male STI). (Source: National AIDS Programme and Ministry of Health, Myanmar).^[41]

HIV/AIDS SITUATION IN THAILAND

HIV/AIDS prevention is complex and difficult to carry out for many resource-scarce countries. Very few developing countries in the world have implemented effective public policies that prevent the spread of HIV. In Thailand, however, the introduction of effective strategies, which have evolved through a number of stages, has successfully controlled the spread of HIV. Thailand has shown that a well-funded, politically-supported and shrewdly-implemented response to HIV/AIDS can effectively change the course of the epidemic.^[27]

The first case of AIDS in Thailand was reported in September 1984.^[42] As with western countries, early AIDS cases were largely reported among homosexual males. The virus was later transmitted through injection drug users and sex workers. Further, it has been suggested that from these groups, HIV spread to sexually active men and women, eventually appearing in the general public.^[27] Subsequently, HIV/AIDS became a major public health concern in Thailand as it came to affect the health, social life and economy of a growing number of Thai people.

At the beginning of the epidemic, the Thai government took a few preventive measures against the transmission of HIV, aimed particularly at high-risk groups.^[27] In 1986/1987, the royal Thai government conducted a series of surveys among commercial sex workers (CSW) in tourist areas, inmates in various prisons, and drug dependent individuals in treatment centers.^[72] In September 1987, the Ministry of Public Health (MOPH) launched a monitoring system on drug dependency among people receiving treatment at the Thanyarak Hospital, Thailand's largest inpatient hospital in Bangkok.^[72] In February 1988, the Bangkok Metropolitan Authority launched a serial cross-sectional survey of HIV infection; these surveys found that HIV prevalence levels had risen to above 30% within eight months.^[72]

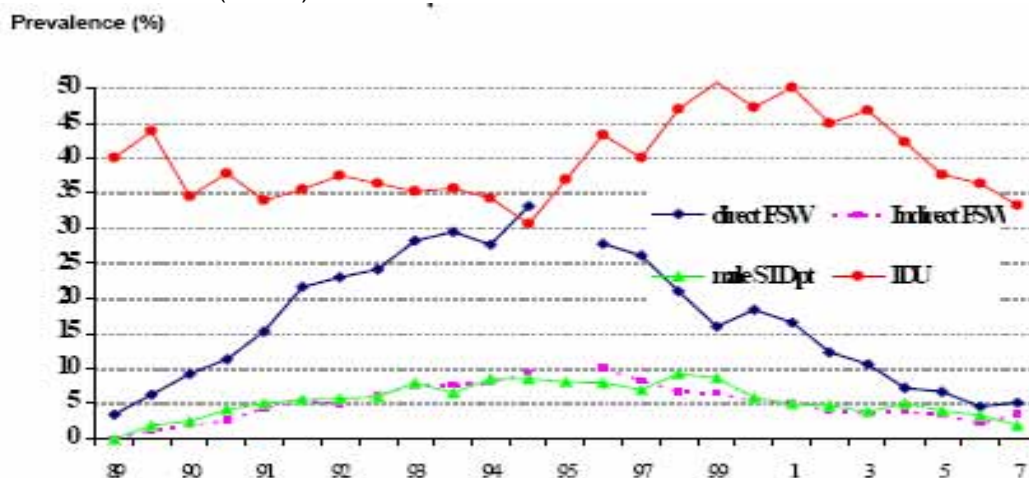


As research emerged on the epidemic, policy makers began to recognize the depth and complexity of HIV/AIDS issues in Thailand and decided to employ the use of the National Economic and Social Development process in order to prevent and alleviate the effects of HIV/AIDS.^[52] In 1990, Thailand's official AIDS policy was announced together with the establishment of a National AIDS prevention and control committee under the Prime Minister's chairmanship.^[72]

In the interim, a media campaign providing public information on HIV/AIDS prevention was launched.^[4] Mass media messages emphasized prevention through behavioral change and condom use. The Royal Thai government approached the HIV/AIDS problem as a social issue rather than as a public health concern.^[4] Personal stories of Thai people living with HIV/AIDS were widely broadcast on public television and radio programs. The injustices that were portrayed in the media about Thai people living with HIV/AIDS dramatically increased public sympathy and awareness of HIV/AIDS.^[4] As a result, Thai civil society was responsive and played a large role in preventing and reducing the stigma often associated with HIV/AIDS.

In 1991, the royal Thai government adopted a nationwide condom program which advocated for the correct and consistent use of condoms.^[52] While prostitution continued to be illegal in Thailand, authorities nonetheless adopted a pragmatic approach to HIV control which encouraged widespread condom use and collaboration among public health officials, brothel owners, local police and sex workers.^[72] Thailand has an extensive network of sexually transmitted infection (STI) clinics and public health services for commercial sex workers that make the monitoring of condom programs feasible.^[72] Numerous politicians and community leaders actively participated in nationwide condom promotion programs. Among them was *Mechai Viravaidya*, who spearheaded an aggressive national campaign to promote the use of condoms in Thai society and became internationally referred to as the "condom king".^[4]

A number of provinces in Thailand have developed local monitoring systems for their specific HIV/AIDS situations.^[72] The data indicate that the overall national prevalence rate has noticeably declined since 2001. In 2003, however, the HIV prevalence rate in high-risk groups was still elevated, especially among intravenous drug users (42.2%) and heterosexual "straight" female sex workers (7.64%).^[52]



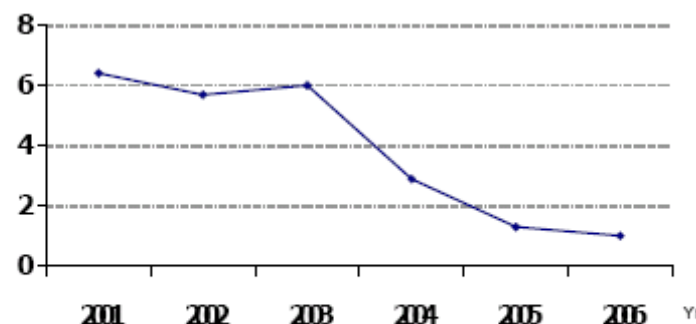
Source: HIV serosurveillance, Bureau of Epidemiology

Figure 5 - HIV prevalence (percentage) among female sex workers, male STI clinic patients and IDU in Thailand from 1989 to 2007.^[51]

Notably, these figures did not contain the prevalence of HIV among migrant workers. This is of great concern as economic stress in neighboring countries puts many people from Southeast Asian countries in a position where better economic opportunities are sought in Thailand through migration. Only a small portion of these migrant workers have legal (registered) work permits; most of them are illegal migrants.^[36] These unregistered (illegal) migrant workers have limited access to the Thai health care system and, by extension, preventive information on HIV/AIDS.^[17] Although HIV statistics for this mobile population are not available, the general pattern of prevalence among foreign migrants tends to be much higher than that among the general Thai population.^[72]

Nevertheless, a series of successful campaigns in Thailand have helped reduce the national HIV prevalence rate.^[4] Thailand has also invested the majority of its current HIV/AIDS budget on the care and support of HIV-positive individuals and their families. The Government Pharmaceutical Organization (GPO) is now producing a generic triple combination of highly active anti-retroviral therapy (HAART), which is helping many HIV-positive and AIDS patients and also helping to reduce the Thai government's budget expenses.^[52] Since 2003, the national policy has shifted to expand a program that covers anti-retroviral therapy (ARV) to every HIV patient that is in need; this is known as the "National Access to Anti-retroviral Program for people living with HIV/AIDS (NAAPHA)" program.^[52]

Thailand has another national program called Prevention of Mother to Child Transmitting of HIV (PMTCT), which has also been successfully implemented. This program uses a short course zidovudine (AZT) treatment and substitutions for breast milk (a common mode of transmission).^[52] Between 2001 and 2003, the transmission risk of HIV from mothers to their children was reduced to about 10% with the advent of these interventions.^[55] In 2005, 98% of women who delivered their babies in public facilities received HIV counseling and testing, and of those found to be HIV positive, 94% received anti-retroviral preventive therapy (WHO, 2007). Due to this prevention program, the rate of mother to child transmission was reduced from 25.5% in 1995 to 6.4% in 2001. The rate then reportedly declined to 1.3% in 2006.^[15]



Source: PHOMS, Bureau of Epidemiology

Figure 6 - HIV transmission rate (percentage) from pregnant women to child from 2001 to 2006.^[51]
(Source: Perinatal HIV Outcome Monitoring System, PHOMS)

The Thai government provides free HIV medication for those with CD4 counts lower than 200/mm³ regardless of AIDS symptoms. The government also provides drugs for opportunistic infection control.^[51] As of 2007, the Thai government has provided ARV to 84.8% of all Thai with HIV whose CD4 count was below 200/mm³ free of charge.^[51] Social and financial support for Thais living with HIV and their families are mainly served by not-for-profit community organizations and faith-based organizations. Thailand also has many social networks available to people living with HIV/AIDS. There are more than 900 HIV organizations in Thailand with more than 900,000 members nationwide.^[15]

Thailand has successfully implemented care and support programs for people living with HIV/AIDS.^[17] The Thai government's collaboration and networking with international HIV organizations facilitated this success. With the help of UN agencies, contributions were made through their support for advocacy, planning, training, research, and policy reviews, as well as a considerable number of implemented activities that were technically regional in nature.^[51] The Thai National AIDS Program has also received plenty of international support for its HIV/AIDS prevention and care projects. The Global Fund has been the largest external input into Thailand's HIV/AIDS resources (about \$109,353,700 over 5 years).^[52]

Overall, the number of new annual HIV infections in Thailand continues to decline.^[51] Fewer than 51,000 new HIV infections were estimated to have occurred in 2008, compared to approximately 140,000 per year at the peak of the country's HIV epidemic in the early 1990s.^[51] An estimated 1.4% [0.7%– 2.1%] of adults in Thailand were living with HIV in 2005.^[55] However, despite the overall achievements that have been made in reversing the spread of HIV in Thailand, prevalence among injecting drug users and among Thai women is on the rise.^[56] Therefore, it is necessary to identify new sources for infection among vulnerable groups and to continue to implement effective prevention programs and sustain achievements in care and support programs in Thailand.

DISPLACED BURMESE LIVING WITH HIV/AIDS IN THAILAND

"An estimated two million people have fled poverty, lack of opportunity and oppression in military-ruled Burma (Myanmar) to work on Thai construction sites, fishing boats, farms, factories and in kitchens, often taking dirty, dangerous or dull jobs that Thais are unwilling to do."

UN Office for the Coordination of Humanitarian Affairs, August 2007.^[17]

The Burmese military junta's gross economic mismanagement, human rights violations, and its policy of using forced labor are all compelling people to leave Burma (Myanmar).^[1, 8] With the declining economic situation, many people from a broad range of sectors leave Burma (Myanmar) for the more prosperous neighboring Thailand.^[1, 71] Over 2 million Burmese migrants are estimated to be working in Thailand, with less than 500,000 of them are working legally.^[32] These numbers are increasing everyday.^[16, 37] Burmese people migrate to Thailand with dreams of finding a better life. In reality, the lure of employment and the quest for a better life put these individuals in physical danger and make them vulnerable to violent crimes such as murder, which further explicates what the migrant population already suffers.^[32]

On April 10, 2008, 54 Burmese migrants died of suffocation in an enclosed truck container while being transported in southern Thailand.^[23, 62] Their bodies were discovered when the cramped truck was opened. The dead included 36 women, 17 men and an eight-year-old girl.^[23] But this is only the tip of the iceberg; there may be many more unreported cases. No matter how challenging and dangerous it is, the negative impacts of pursuits such as these do not halt Burmese people's endeavor to migrate into Thailand. It is not uncommon for migrant workers to be killed or seriously injured as they attempt to enter Thailand illegally.^[1, 40]

As a result of the impact of cyclone Nargis which hit the delta region of Burma (Myanmar) in 2007, the influx of Burmese people has increased dramatically.^[40, 62] Burma's economic troubles contributed to the large number of human traffickers in 2008, keeping them busy at a time of year when wet conditions in the rainy season traditionally usually slow the flow of migrants across the border into Thailand. It is estimated that about 300 Burmese migrants are illegally transported to Bangkok each day from the Thai-Burma border.^[40, 62] Burmese workers in Thailand are the easiest prey for international and Thai employers. Burmese workers have a high threshold for exploitation and are willing to work long hours in unsafe conditions for wages well below Thailand's minimum wage,^[17] as it is often better than the conditions they face at home in Burma (Myanmar).^[1]

Burmese migrants have to work long hours daily with minimal pay. On average, Burmese migrants receive about half of the set minimum wage on Thailand.^[2, 14, 41] This is also applied to registered (legal) Burmese migrants, who get lower than minimum wage. In addition to exploitation various abuses, including murder and rape, are common and are usually unreported.^[1] This is because migrant workers are reluctant to get involved with the Thai police.^[17] Unregistered migrants fear deportation if they complain to the authorities.^[32] A large pockets of migrant workers are found in Mae Sot, which is the most popular point of entry into Thailand. Mae Sot is separated from the neighbouring Burmese town of Myawaddy by the Moei River.^[2, 62] This is where cases of abuse are particularly high. Also, it is important to note that many Thai people have negative perceptions of Burmese migrant workers which exacerbate the problems Burmese migrants already face.^[1]

**"All persons are equal before the law and shall enjoy equal protection under the law.....
Unjust discrimination against a person on the grounds of the difference in origin, race,
language, sex, age, physical or health condition, personal status, economic or social
standing, religious belief, education, or constitutionally political view, shall not be
permitted."**

Section 30 of People's constitution, Kingdom of Thailand.^[1]

Most Thai citizens are ignorant of the positive contributions that migrant workers make to the Thai economy.^[1] In 2007, a study done by International Labour Organization (ILO) stated that "If migrants are as productive as Thai workers in each sector, their total contribution to output should be in the order of US\$11 billion, or about 6.2% of Thailand's gross domestic product [GDP]".^[14] Estimations of migrant worker contributions towards the Thai economy is approximately 370 billion Baht (11.45 billion Canadian dollars).^[14, 23] As a result, the Thai economy has become increasingly dependent on the low-priced migrant labour and Thai labour shortage problem has only been released only with the entry of both legal and illegal migrants.^[2] Thai employers have conspired to suppress this information and exploit migrant labourers to maximize profits.^[2] Recognizing that the Thai economy is dependent on migrant workers, the Thai government should develop a socio-economic justification for migrant workers, and work with employers and unions to develop co-operative mechanisms to manage labour migration and to protect migrants.^[1] Sadly, migrants are not treated with respect and violence directed at Burmese migrants in Thailand is on the rise.^[1, 23]

The Burmese migrant population has limited knowledge regarding HIV/AIDS and other infectious diseases due to the dire situation in Burma.^[71] Due to their limited mobility and lack of official documentation, they are unable to access Thai public health services.^[36] This issue is further compounded by language and cultural barriers. Also, drug related crime, sexual abuse and human trafficking problems are highly concentrated on Thai-Burma border. The Burmese migrant population in Thailand bears a disproportionately high burden of infectious diseases, particularly HIV, undermining the progress made by Thailand's public health system in controlling these public health concerns.^[45] In particular, gender discrimination on Burmese girls inevitably compounds vulnerability for migrant women in Thailand, resulting in 'double marginalization'.^[2]

The migrant women are the most vulnerable to sexual violence and have increased vulnerability to being trafficked into prostitution.^[7] The majority of Burmese migrant workers in the Thai sex industry experience violence, forms of coercion, deception, and abuse of power.^[2, 7] There is also a high occurrence of co-operation between the Thai authorities and human traffickers.^[1] Migrant women and girls are exposed to additional risks because of their gender, including sexual harassment and abuse, rape, unintended pregnancies, and unsafe abortions.^[36] Generally, migrant women in Thailand are highly vulnerable to HIV/AIDS and other sexually transmitted infections.^[1] As a result, untreated STI contribute to migrants' HIV/AIDS vulnerability, and unplanned pregnancies result in unsafe abortions and other reproductive health problems.^[36]

An exact estimate of the number of Burmese migrants living with HIV/AIDS in Thailand remains unknown. However, data collected by local and international NGOs and community based organizations on the Thai-Burma border illustrate that the number is increasing each day.^[16, 71] This suggests that there is a direct relationship between human rights violation, migration and increased health problems such as HIV/AIDS.^[20] The data also implies that human rights violations are at the root of various health problems, especially HIV and other infectious diseases.^[1] Life is very difficult for Burmese migrants living with HIV/AIDS in Thailand.^[24, 29]

There are many challenges for Burmese migrants living with HIV/AIDS.^[24] Some of them live in makeshift housing with no electricity, running water, or sanitary facilities.^[24] Others live in Burma where one risks arrest for carrying supplies to sick patients, and individuals with HIV/AIDS face deep social stigma and discrimination associated with the disease.^[17, 25] They often lack

fundamental social and cultural support in Thailand, further compounding their precarious situation.^[29] Lack of family and social support is a significant concern when people become ill as they are often isolated from family and friends and are left to care for themselves.^[26] Some migrants with HIV/AIDS die alone in their makeshift homes and often following death, there are no existing funeral arrangements in place.^[26]

Treatment options for Burmese migrants living with HIV/AIDS are limited on the border as well.^[29] Due to their illegal status in Thailand, they cannot freely check into clinics or government hospitals.^[17, 36] Since there is always a risk of deportation and arrest on their way to the medical centers, some Burmese migrants avoid seeking health care.^[45] The increasing number of Burmese migrants living with HIV/AIDS puts a disproportionately heavy burden on local NGO and community-based organizations for HIV care and support programs in Thailand.^[24] The documented number of HIV infected people is increasing as the number of people seeking care in and around the Mae Sot area rises.^[26] Some of them migrate to Thailand to get medical treatment for HIV infection. In addition, the need for long-term support and treatment expands as previously diagnosed patients continue to seek treatment and care.^[26]

The health care and legal services for displaced Burmese living with HIV/AIDS in Thailand are in great demand. I have interviewed some displaced Burmese living with HIV in Thailand. Summaries of their experiences are published here. Consent has been obtained to express their life experiences with their pictures to publish in this report to the IDRC.

PERSONAL ACCOUNTS OF DISPLACED BURMESE LIVING WITH HIV/AIDS

Personal Accounts of Displaced Burmese with HIV/AIDS (1)

I do not blame my husband for infecting me with HIV. He was a simple and hard working man. He died of HIV in 2001 at Pha An General Hospital in Burma. I was certain I had HIV after he died. My health started to decline in 2003.

In early 2003, I had chronic vaginal bleeding and consulted a gynecologist in Burma. The symptoms of lower abdominal pain and bleeding were recurrent and I could not afford to get treatment. I had only one option, so I left Burma for Thailand. It was well known in Burma that there was a clinic on the Thai-Burma border which provided free medical and in-patient care. In addition, I had to think about my four children; the youngest is 6 and the oldest are teenagers.

The gynecological symptoms did not subside. Finally, I sent my kids to the local Baptist Church, and headed to the Thai-Burma border for free medical treatment in mid-2003. The clinic staff advised me to have blood test for HIV. The results were positive. I did not worry so much about myself because I expected to have HIV, but I worried about my children who were left in Burma. I needed to recover quickly because I wanted to work in Thailand to support them.

Once I recovered from the vaginal bleeding and abdominal pain I was discharged from the clinic. Now I live in and run errands for a local migrant school. The school provides me with a place to sleep. I also work cleaning Thai houses and in near by paddy field harvesting crops. The work is irregular in nature and most of the time I am unemployed. At least, it allows me to send some money to my children in Burma, for their education.



"I wish I could see my kid before I die"

In late 2007, I had severe weight loss and became frail. I could not walk anymore. The Mae Tao clinic staff helped me and did a blood test to check my CD4 count, other basic blood tests and to monitor my HIV infection. My CD4 count was 14, which meant that I had AIDS, the

last stage of HIV infection. The clinic helped me to get Antiretroviral (ARV) medications from a Thai hospital. I regained 20 kg within 3 months.

Despite having these medications, I am not completely recovered. Breathlessness and muscle weakness affect me daily. I cannot work as I did before and as a result I can no longer send money to my children in Burma. I worry about their education and future, but there is nothing more I can do about that. I want to bring them to Thailand; at least for a few days. I have not seen them for more than 5 years and if I die I will never see them again. However, even for me, living is so difficult. At the local migrant school, I have a place to sleep otherwise I would have nowhere to sleep. Due to the work of local NGOs, I get food; otherwise I would have no food to eat. Due to the Thai hospital, I receive medication for HIV, otherwise I would be dead. However, getting these HIV medications for the long run is still uncertain. Moreover, I do not think I have much longer to live with AIDS. Everyday I wish that I could see my children before I die. **(This personal interview was conducted on 13 December 2008)**

Personal Accounts of Displaced Burmese with HIV/AIDS (2)

I could not believe that my wife would leave me in such a desperate situation. I had a persistent high fever and immense swelling in my neck. We had been married for nearly 6 years, since 2002. We had a 5 year old son. Sadly, when she left she took my son as well. I do not know where they are now.

The problem started in early 2008. I noticed a swelling on the left side of my neck. It was about the size of a man's fist. I tried to treat it with different traditional medications and antibiotics in the hope that it would subside. However the swelling never went away. The appearance of swelling was coupled with severe weight lost, so my wife thought that I had some kind of cancer and that I was in the terminal stage.



"I do not know where my family is"

I can understand that nobody wants to live with a cancer patient and care for them. I do not blame her for leaving me. However, I was sad that she took away our son. My day to day life after they left was very difficult and I always missed them. Sometimes I could not sleep for 3-4

consecutive days because I was longing for their return. I was physically disabled because of the swelling and weight loss and psychologically broken due to the separation from my family.

After 3 months, I was admitted to a local Aide Médicale Internationale (AMI) hospital. At the AMI hospital, I was diagnosed with TB (Tuberculosis) neck gland swelling and received surgical treatment. The AMI staff and counselors suggested I also get tested for HIV. The test showed that I was HIV positive. It took 3 months for me to recover for the TB neck swelling at the AMI hospital and it was more difficult because I had no family support.

My CD4 count was very low, so I was referred to the Medecins Sans Frontieres (MSF) hospital to get Anti-Retroviral (ARV) medications for HIV. I am currently receiving ARV and my health is improving every day and I have regained my appetite and am gaining weight. However, I still need to stay in the MSF hospital to receive continued treatment for TB. I want to have a normal life as soon as possible and begin working again. I need some money to repay the debt my wife built up before she left me.

My wife borrowed 8000 Baht (about 280 CAD) from people in our neighborhood, so my neighbors always ask me to repay that money. I cannot work these days and I do not know how to make 8000 Baht. For now, I am supported with food, shelter and medication at the MSF hospital. But this food and shelter will only be provided for the period during which I am taking medication for TB. After that I will have to earn living for myself, even though I am HIV positive. If I had money, I might be able to reunite my family. I know tuberculosis can be cured with TB medications and that people living with HIV can have a normal life if they receive regular HIV medication.

Some people say that MSF is going to pull out from the Thai-Burma border next year. If there is no MSF, I will have no more ARV drugs, which is life saving medications for people living with HIV like me. These drugs are very expensive to buy. If there is no more HIV medication, I will not have a future. I do not want to die. I want to see my son and my wife. I miss them everyday.

Every night, it is very difficult for me to sleep well. Sometimes, I cannot sleep the whole night because I am longing to see my family. When I do sleep, I dream that I am getting a regular supply of ARVs and that I am working as I did before. I also dream that I am with my family.

(This personal interview was conducted on 14 December 2008)

Personal Accounts of Displaced Burmese with HIV/AIDS (3)

I am from Bago which is a large city near Rangoon, Burma. I divorced and had to take care of my son so I needed a job to support us. My health was perfect when I was in Burma. However, while I was there it was so difficult to make ends meet. At that time, some of my friends said it was easier to find employment in Thailand. So, I decided to leave Burma for Thailand. In 2006, I decided to leave my son with my relatives and I illegally moved to Thailand on my own.

The problem started on my way to Thailand. The journey was so harsh and I experienced fevers during my travels. After a few days, I arrived at the Thai-Burma border, in Myawaddy city. The fever never subsided and I lost my appetite. I did not have enough money to get treatment, so finally I was admitted to The Mae Tao Clinic, on the Thai side of the Thai-Burma border.

It was there that I was diagnosed with HIV. The clinic provided me with shelter, food and medication for my fever but they did not have antiretroviral (ARV) medication to treat my infection. After receiving care for a week, the fever subsided and I felt normal again. I then started looking for a job in Thailand as a house keeper.



"I have a big idea to be together with my son again"

This did not last long. After three months, the fever came back and I was readmitted to The Mae Tao Clinic. Everyday, I suffered from a very high fever, breathlessness and a cough with sputum production. I was later tested for Tuberculosis (TB) and the test was positive. So, there was HIV virus in my blood and TB bacteria in my lungs. My body weight was diminishing everyday and I was barely able to resist the affects of these two infections.

I decided to commit suicide but other patients and health workers were so kind and they always deterred my attempts. I tried to jump into the river and also hang myself. All my attempts were unsuccessful because of my friends and the nurses at The Mae Tao Clinic. The clinic provided me with medications for TB and also they helped me get ARV from The Mae Sot Hospital. After taking the medications, I felt much better; the fever went down and my appetite returned.

The clinic referred me to Medecins Sans Frontieres (MSF) TB village where I received free shelter, food and medication as long as I continue to take anti-TB medications. Now I am gaining weight and feel healthy again. However, I realize that receiving long-term HIV medication is not guaranteed. The other patients at The MSF TB village said MSF is going to pull out from Thai-Burma border. Everyday, I pray that I will continue to receive a consistent supply of HIV medication. These medications are so expensive that without the assistance of MSF, I will not be able to afford them on my own.

If I lived in Burma, I would not receive HIV medications. I know if I go back to my city in Burma, I can see my son but I cannot go back because I need a regular supply of HIV medications to stay alive. However, I have an idea that will allow me to be together with my son again. Once the TB treatment is finished, I will work here in Thailand. Once I have enough money, I will take my son with me to Thailand so we can have a happy family like we dream of.

(This personal interview was conducted on 14 December 2008)

Personal Accounts of Displaced Burmese with HIV/AIDS (4)

I was a jade mineworker at Phar Kant, in northern Burma. As a jade mineworker, I could not make a lot of money. I have some money for my family who live in the southern part of Burma. In 2002, the Burmese military controlled the jade mine in that region. When they took control, the public jade companies could not compete and as a result, I became unemployed.

I came back to my family in southern Burma, at Phar Pon city. We have a 12 year old daughter. Making money for 3 family members was difficult for me. I worked various jobs, to support my family; however, our family never had enough food. My daughter dropped out of school to help my wife, but we continued to struggle economically. I frequently skipped meals so that my wife and my daughter could eat.



"I have some HIV medications and some food for this morning"

Under these difficult situations, my health began to deteriorate. I developed a frequent cough and had difficulty breathing. I consulted a clinic and they told me that I had tuberculosis. I consulted with the government hospital but they asked me for more money than I had for the treatment. So I lived without treatment knowing that my lungs were infected with tuberculosis. At one point I could hardly breathe and I finally had to leave Burma to go to the Thai-Burma border for free medical treatment.

I arrived at Mae Tao Clinic in December 2007. The clinic helped me get TB treatment. They also taught me about the HIV virus and helped me have a blood test. I found out that I am infected with HIV. To get better treatment for both HIV and TB, the clinic referred me to the Medecins Sans Frontieres (MSF) hospital on the Thai-Burma border. The MSF doctors said the TB infection I had was resistant to regular TB medication.

With TB treatment from MSF in combination with HIV medications, I felt much better. I still live in MSF TB village with is about 20 km away from Mae Sot, together with my family. While I was on TB medication, MSF supported me and gave me staple foods. However, now that I have completed the anti TB course, my family no longer receives food.

I am glad that my family is allowed to live in the MSF TB village. We have shelter. I am also receiving HIV medications. These medications are important for me to stay alive. For food, I beg my friends and nurses to offer me some rice. We often have rice gruel with some vegetables my wife picks from near by hillsides. I know I can get some staple food support from NGOs in Mae Sot, but transportation is a problem. I do not have legal status in Thailand. If I were captured by the Thai police on my way to get food support, I would be deported back to Burma. There is no way to get HIV medication in Burma. If the Thai police deported me back to Burma, it will be a death sentence.

I am not fit enough to work yet but we are lucky that we can eat rice-gruel frequently. It was a gift from God that I got medical treatment for both TB and HIV. Some people say there will be no more MSF hospital or HIV medication supply next year. I do not want to think about that. Instead, I live for today and I take my HIV medication regularly. I am fortunate to be alive today.
(This personal interview was conducted on 15 December 2008)

Personal Accounts of Displaced Burmese with HIV/AIDS (5)

When I was healthy, I had a wife and an eight year old son. My wife and I worked at a local factory where we had worked for more than six years. We were not rich, but our combined income was enough to live on and purchase basic necessities. In general, our family life was simple and happy.

In May 2008, I began experiencing a persistent cough and fever. As a result, I visited a health clinic where I was diagnosed with Tuberculosis (TB) and began taking anti-TB medications. Following the diagnosis, I began receiving voluntary counseling and testing services for HIV at The Mae Tao clinic. Later I was also diagnosed with HIV. Following the diagnosis, I encouraged my wife to get tested but she refused. Due to my chronic TB symptoms and for a better clinical care for TB, I was referred to a Medecins San Frontieres (MSF) hospital in Mae Sot, on the Thai-Burma border.



"I have to suffer alone until I die"

Following my TB and HIV diagnosis, my wife left me and took our son with her. She initially told me she was going to Bangkok to make money for our family. I trusted her and believed what she said to be true. As time passed, I realized her intention was to leave, and never return. Since leaving, she has not contacted or visited me. My health began deteriorating and I was advised to stay in the MSF hospital. Here I received treatment without any family support.

During my stay, I learned from MSF staff that I am infected with multi-drug resistant tuberculosis (MDRTB) which is a strain of TB that is resistant to all pharmacological treatments. Despite my continued adherence to anti-TB medication, my symptoms such as coughing, breathlessness and weight loss persist. I also learned that the status of my HIV infection according to my CD4 count was 14, meaning that I am severely immuno-compromised. I am currently receiving medications for HIV. I feel so lucky and thankful that MSF provided me with all the necessary medications, clinical care, food and shelter.

I do not know what it means by severely immuno-compromised and I do not understand much about MDRTB. However, I understand that my disease symptoms are not alleviated despite taking medications. It is hard to explain how much pain I experience as a result of my illnesses and these symptoms.

These days, I cannot eat any solid food and I have lost my appetite. It is also incredibly painful to swallow and I require lot energy to simply take a single breath. I am not feeling better even with continued treatment and medication. I am bound to my bed and I long for my wife and my son to sit near me. The only time I find peace is when I dream of being with my family while I am sleeping; I dream of then often but it doesn't change my current reality. I am alone and I understand that I will continue to suffer alone until I pass away.

(This personal interview was conducted on 15 December 2008)

Personal Accounts of Displaced Burmese with HIV/AIDS (6)

When I first came to Thailand in 2002, I worked as a sales clerk in a shop. I was only 18 at that time. Since my salary was not enough to make living. My friends said I could make a lot of money if I worked in a brothel, so I decided to start working in a brothel. In 2003, I became a commercial sex worker and my friends were right; making money was easy as a sex worker.

I was a careful sex worker. I used condoms correctly and consistently whenever I had sex. I do not want to get pregnant. I used condoms with everyone except my husband; who was one of my regular customers. He was very promiscuous. He was an unemployed gangster who threatened my life to get me to marry him. As a wife, I always took care of him. In return, I wanted him to be a good husband. I hoped he would be faithful to me and he would find a good job to support our family.

I was amazed that he ordered me to keep working as a commercial sex worker. He never tried to get a regular job. He would just spend all the earnings from my job. To make matters worse, he spent a lot of the money to have sex with other women. I realized I had made a big mistake. If I did not give him money, he would beat me several times, and treat me as his slave. Sometimes I could not go to the brothel because of these injuries.



"My husband ordered me to keep working as a commercial sex worker"

In 2007, he got genital warts. I took him to the clinic to get treatment. Later, I also suffered from that disease and had multiple warts around my genital area. At that time, the clinic provided both of us with counseling for HIV and advised us to have a blood test. We both were positive for HIV. I wanted to stop working as a commercial sex worker but he did not allow me to. I disclosed to all my customers that I have an infectious disease and I warned them to use condoms correctly.

But I could not work as a commercial sex worker for much longer. I was losing weight and having abdominal pain. In April 2008, I was admitted to a clinic in Thailand for Burmese migrants. The clinic diagnosed me with abdominal tuberculosis (TB). They also tested my CD4 count, to determine the stage of my HIV infection. My CD4 count was very low at that time. That meant I had advanced HIV infection. I could not eat or walk and I looked like a skeleton. My husband never came to the clinic to see me during my 1 month stay there. Instead, he asked for a divorce. He believed I was going to die, and therefore I was useless to him. I immediately agreed to get divorced.

I struggled alone to recover from that illness. After taking TB and HIV medications for a month, I felt a lot better. I was able to eat more and now I am just like a normal person. I am happy that I could regain a normal life. I am happy that I can work with local NGOs on HIV prevention projects for other commercial sex workers. Above all, I am happy that I am free from a life of slavery with my husband.

(This personal interview was conducted on 16 December 2008)

Personal Accounts of Displaced Burmese with HIV/AIDS (7)

We have only one child. Three months into my pregnancy in 2005, I got a high fever and cough which were associated with weight loss. Due to these symptoms, I was tested for HIV and found to be positive. During my pregnancy, a clinic in Thailand provided me with HIV medication, arranged for an assisted delivery and provided milk substitutes to prevent mother-to-child transmission of HIV. My son was lucky; he is now 3 years old and HIV negative. We are happy to have a son and work hard to feed him, and send him to a migrant school.

We work and live in a paddy field. Our boss is Thai and we have had a good relationship with him for many years. But about a month ago, he found out that we are both have HIV. Now, he treats differently and does not want us to work for him anymore. Most of our friends know that we have HIV and I think he might have heard about our HIV status from them.



"We are not allowed to live here anymore, and we do not know where to go"

Our employer's attitude towards us became so negative that a couple of weeks ago, he told us that he wanted to hire new workers for his field. He also said he is going to burn down our hut and build another one for his new employees. He said we have to move out of here within 2 weeks. So now we are unemployed and homeless. We are supposed to leave today, but we still do not know where to go. We cannot find a new place to live.

Getting a new hut is easy, if you have enough money. We can only dream about renting a hut in nearby fields. We have been dreaming about buying a hut in another field. There are a few huts in other Thai villages, but they cost about 1500 Baht (about 50 CAD) however, we cannot save that much money. When we were working in this paddy field, we had a fairly regular income. My husband is trying everyday to get a job at local construction sites, but it is not easy to get a regular job these days, as an illegal Burmese migrant. He can get a job for 2-3 days a week, but the wage is so low that he can hardly make enough money to buy us food.

This morning, he left our hut early in search of work. He knows we need to buy food. We have some yellow bean which is supplied by local NGOs as a staple food, apart from that we have nothing to eat. He has not come back yet and my son and I are hungrily awaiting his return. We hope that he will come back home with some food.

(This personal interview was conducted on 17 December 2008)

Personal Accounts of Displaced Burmese with HIV/AIDS (8)

I have a 4 year old daughter. She is the only person in the world whom I love the most.

We are originally from the capital of Burma, Rangoon. In 2005, we came to Thailand. It was very difficult to make ends meet in Burma. We had hoped that it would be easier to survive in Thailand, as illegal migrant workers. Last year, my husband had high fever and persistent diarrhea, so he was admitted to The Mae Tao Clinic in Mae Sot. Despite treatment, both the fever and the diarrhea did not subside. The clinic advised him to have blood test for HIV. He was found to be HIV positive.



"I need someone who could take care of my HIV positive daughter when I die"

Both my daughter and myself were also found to be HIV positive too. I feel very sorry our daughter. Our innocent daughter got HIV from us. At that time, I could not think much about myself and my daughter. I took care of my husband and nursed him as best as I could. The Mae Tao Clinic also treated him to the best of their ability. However, two weeks after admission to the clinic, he died. We have been helpless since then.

We live mainly on staple foods supplied by local NGOs. It is not enough to live on. I make souvenirs at my home, but I cannot work long periods of time. My health situation is not very good. I frequently suffer from breathlessness and a low grade fever. I have requested that the clinic prescribe me ARV medication for my HIV infection, but they said my CD4 count is still high. As a result, I do not get any HIV medication yet.

Getting HIV medication is crucial for us. I am especially concerned about my daughter. She will certainly need HIV medication at some point in the future. That is why I cannot go back Burma. I have some relatives in Burma, but, if my daughter is in Burma, she will not get HIV medication. So she needs to stay on the border. I am not concerned about myself.

The clinic says my CD4 count is still good and that I am in good condition. However, I do not think my health is good. I have frequent fevers. I do not think I have long to live. I have to die

sooner or later, as my husband did right before my eyes. Today, I am not feeling well. I could not cook and I could not send my daughter to pre-school. I could not prepare a lunch-box for her. I want her to be at pre-school regularly, but today I have run out of energy. I want her to be educated; however, all I can do for today is ask her to sit near me. I love her very much.

I want my daughter to be near me so long as I am alive. I want to take care of her as much as I can, but that won't be last forever. I will have to give my daughter to someone else when I die. I want to give her to someone who can take care of my daughter as much as I do, send her to school and provide food and shelter for my daughter. I really need someone who will love my HIV positive daughter.

(This personal interview was conducted on 22 December 2008)

Personal Accounts of Displaced Burmese with HIV/AIDS (9)

I confess that I was a man who frequently had sex with other men. I have been in Thailand since 1987. I can speak Thai very well and I have a Thai working permit. When I first arrived, I did not know what HIV was. At this time, I enjoyed having sex with other men, two to three times a week and I did not use condoms.

In 2006, I experienced fever-like symptoms off and on for one year. I took several remedies in an attempt to feel better. But the fever persisted. Health workers at The Mae Tao Clinic offered me volunteer counseling and testing for HIV and I was found to be HIV positive in 2007. I participated in risky behaviors and I encountered problems related to HIV. I am really sorry that I had sex without using condoms for protection and now I have HIV for which no curative treatment exists.



"I am concerned that many Burmese migrants who have sex with men do not know well about HIV infection"

In May 2007, I began to experience the persistent coughing and fever-like symptoms again. I received treatment from the clinic but I did not feel better. Three months later, I had a sputum test for Tuberculosis (TB) and I was found to be positive for TB. At that time, my CD4 count, which was the indicator of the progression of the HIV virus in my body was very low. As a

result, I had to take both antiretrovirals (ARVs) for HIV and anti-TB medications that I received from Medecins Sans Frontieres (MSF). Now I am feeling better and I experience no disease symptoms. However, I worry about how I will continue to receive treatment once MSF pulls out from the border. Also, I worry about other men who have sex with men (MSM) on the border. There are many displaced Burmese MSM on the border who may also be at-risk of HIV and possibly some who are currently in need of care.

I can say that there are more than 300 displaced Burmese MSM. They do not know about HIV and modes of transmission. I have told them about the danger of HIV infection for the MSM population. Unfortunately, condoms are not easily accessible for displaced Burmese MSM in Thailand. One issue of concern is that it is very expensive for us to buy condoms. Some of my friends who are also MSM, died in the last few months. They were ashamed to disclose their HIV status. I fear that more MSM will die of this disease.

Considering my experience, I have the opportunity to inform others about HIV. There are many displaced Burmese MSM who are in need of HIV related information. I wish there was an effective HIV prevention program for MSM who otherwise do not have access to HIV education from the Thai health system. If I do not receive ARV from MSF or other resources, death will be inevitable for me. Further, if displaced Burmese MSM do not receive HIV information, many people will die unnecessarily and this concerns me, greatly.

(This personal interview was conducted on 22 December 2008)

Personal Accounts of Displaced Burmese with HIV/AIDS (10)

It is hard to tell you the exact year I left Burma; I do not remember. I think it was 15 years ago. I am originally from the eastern part of Burma and I belong to the Shan ethnic group. When I was a teenager, human traffickers came to my home town. They told me how fantastic life was in Thailand. I immediately agreed to allow them to send me illegally into Thailand.

I had to hide in a cargo truck to get into Thailand. It was a really uncomfortable journey, but it was worth it to be hidden in a truck. After few hours drive, I finally arrived at a city called Bangkok. As a beautiful teenager, it was easy to get a job in Bangkok. At first, I worked as a dishwasher at a Thai restaurant. I learned to speak Thai from my co-workers. After a few months, I got at a management position at the same restaurant.



"I have nothing nowadays but HIV infection"

Those were some of the most amazing days of my life. As I was an intelligent, young beautiful girl, the son of the restaurant owner approached me and asked me to marry him. I liked him but his parents did not agree to allow their son to marry me. This was because I was an unregistered Burmese migrant worker in Thailand. However, we married in secrecy anyway.

When my parents in law noticed that we were living together outside the restaurant, they started to put me down and described my presence in Thailand as illegal. After a year marriage, I could not put up with my parents in law anymore. I decided to run away from them and told my husband that I was going to go and visit my relatives in Burma. I moved to a city on the Thai-Burma border called Mae Sot. I thought I could save a lot of money working as a manager in a restaurant in Mae Sot.

I had a lot of experience working for a restaurant in Bangkok, so I started working in a bar in Mae Sot. As I was a beautiful young lady, I got a lot of tips from the customers. Those days, I spent money like it was water. I lived a perfect life for a couple of years until I had a motorcycle accident. After that accident, I was hospitalized for many months. I could not walk anymore; I was paralyzed though I was a young woman.

While I was receiving treatment for my paralysis, I got several injection abscesses on my buttocks. I got frequent fevers which were resistant to treatment and I started to lose weight every day. The hospital staff suggested I have a blood test for HIV. I tested positive for HIV. I did not care about that infection as I believed that there could be treatment for any disease. The problem, however, was that I could not afford to get treatment at Mae Sot hospital. As I was an unregistered Burmese migrant, receiving treatment in Thailand was too expensive. After receiving treatment for paralysis for about 6 months, all my saving had run out and I had to find another place to receive treatment for both paralysis and HIV infection.

This was how I got to Mae Tao Clinic which provides free treatment for Burmese migrants in Mae Sot. During my first days at the clinic, I only weighted about 30 Kg. I was a psychotic and paralyzed patient and I was gradually losing my vision. The clinic had my CD4 count tested to determine the stage of my HIV infection. I had advanced into late stage HIV infection. The clinic helped me get ARV drugs for my HIV infection.

I do not know how long I have been in this clinic. People say I have been here for more than 2 years. I do not know how old I am. People say I am a 30-35 year old woman. I eat well and sleep well everyday. After receiving a regular supply of ARV medication, I am now an obese woman. However, I do not have good vision and I cannot walk. Whatever happens to me, I do not care. I do not think about what was happened to me in the past and what will happen to me in the future. Life is always uncertain, but one thing I can say you for sure is that I will never leave this clinic.

Life is always moving up and down, but I do not see any ups in my future. I do not have relatives, friends or money. I also do not have legal immigration status in Thailand, free physical movement or clear vision. The only thing I have now is HIV infection.

(This personal interview was conducted on 23 December 2008)

REDUCING THE IMPACT OF HIV/AIDS

"Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it"

Target 6B, the UN Millennium Development Goals (MDG).^[56, 58]

Thailand has extensive programs addressing HIV/AIDS, which include community-based care and a strong advocacy network of people living with HIV.^[15] In 2001, the Thai government established a new health insurance scheme that included outpatient and inpatient care with prescribed essential medicines. Only registered migrant workers, which represent a small fraction of Burmese migrants on the border, have access to the Thai health insurance.^[36] Since most migrants are not registered due to the prohibitive costs for registration, they could not access the Thai health system.^[31, 71]

Royal Thai government provides antiretroviral (ARV) medication for all pregnant women living with HIV in order to prevent mother-to-child transmission.^[51] The government also provides ARV therapy to its citizens who are in need of treatment.^[52] Currently, only a small fraction of migrants workers have access the therapy. Therefore, most of the migrant population has difficulties accessing these services in a real setting, due to language barriers, transportation restrictions, financial barriers and their immigration status.^[37, 71]

HIV/AIDS care and support programs are almost non-existent on the Burmese side of the border.^[30] It has been reported that at the Myawaddy hospital, which is the Burmese government-run hospital close to Mae Sot, ARV treatment is only available for 25 HIV/AIDS patients (less than 15 patients are receiving ARV from Myawaddy currently) and there is currently no capacity to provide free-of-charge hospital care or laboratory testing. Some Burmese migrant workers living with HIV said that they came to the Thai-Burma border solely to receive care and support for their infection with HIV.

HIV care and support work is very complex; it includes voluntary counseling and testing, psychosocial and peer support, financial assistance and income generation, nutritional and food support, laboratory and blood work, ARV therapy and treatment of opportunistic infections, inpatient and AIDS care and preventative health measures. No single health organization can feasibly handle all this work given the current situation. It is also difficult for international organizations to provide long-term care and support programs for this chronic problem. These facts raise concerns about what organizations will remain in Thailand and handle these complex problems associated with the displaced Burmese population.

A large majority of displaced Burmese are concentrated on the Thai Burma border, in Mae Sot.^[2] On that border, the Thai Government's Mae Sot Hospital, International NGOs including Medecins Sans Frontieres (MSF), Aide Medicale Internationale (AMI), World Vision Foundation of Thailand and Community Based Organization (CBO) like the Mae Tao Clinic provide care and support services for displaced Burmese living with HIV/AIDS. The Migrant Action Program (MAP), works on addressing HIV prevention and health education among Burmese migrant factory workers. Due to Burmese migrants' legal status in Thailand and their mobility, these organizations have to overcome many obstacles in implementing HIV/AIDS related services. Structured interviews were conducted with organizations on the Thai-Burma border which provided care and support for the displaced Burmese living with HIV/AIDS in Thailand. The succeeding sections explain about these organizations.

Mae Sot General Hospital (MSGH)

The "National Access to Antiretroviral Program for people living with HIV/AIDS (NAAPHA)" program is being implemented by the Thai Ministry of Health, and is funded by The Global Fund. Under this 6 year project (2007-2013),^[52] the Thai government's Mae Sot Hospital can provide free ARV and HIV related blood testing which include a CD4 count, viral load and drug resistance testing for up to 100 Burmese migrants living with HIV.

However, this program does not cover patients' transportation, drugs for opportunistic infection control, hospital stay and other miscellaneous treatment costs. As of January 2009, Mae Sot Hospital was providing free ARV therapy for 60 Burmese migrants living with HIV whose CD4 count measured lower than 200/mm³ regardless of their legal status in Thailand. However, ensuring optimal adherence to the provided treatment is left to certain NGOs or CBO. MSGH does not have capacity for patient follow-up. Further, patient follow-up is more difficult for Burmese migrant workers living with HIV due to the mobility of this population. Due to drug adherence challenges, MSGH also requires permanent living addresses in Thailand before providing ARV therapy. There many displaced Burmese living with HIV who remain in need of ARV, although they are not eligible to receive free treatment because they do not have a permanent home address in Thailand. And, these migrant populations do not receive ARV treatment by any other means.

Furthermore, the National Access to Antiretroviral Program for people living with HIV/AIDS (NAAPHA) for migrants will end in the year 2013 after which, even those currently receiving ARV from the Mae Sot hospital will not be guaranteed a regular supply of treatment.

The cost of hospital care is another important issue to consider. When displaced Burmese people living with HIV/AIDS are admitted for hospital care at the Mae Sot hospital, they cannot afford medical care. Currently, community based organizations such as Mae Tao Clinic has to pay for displaced Burmese living with HIV/AIDS who are admitted to MSGH. Even the Mae Sot hospital cannot provide care and support for displaced Burmese with HIV/AIDS; at the very least, there should be free blood work and laboratory services for all displaced Burmese living with HIV/AIDS, since the project is funded by The Global Fund. Other international NGOs like MSF are actively addressing the needs of displaced Burmese living with HIV/AIDS who are co-infected with Tuberculosis.

Medecins Sans Frontieres (MSF)

Medecins Sans Frontieres (MSF) is working primarily with Burmese migrants with Tuberculosis (TB). MSF began treating TB among unregistered migrant workers from Burma and refugees in Mae Lae camp in 1999. MSF began its first antiretroviral (ARV) program, as a part of TB program in Thailand in 2000. MSF worked closely with Thai health authorities and local partners to support Burmese migrant living with HIV/AIDS.

In 2007, 5,234 consultations were conducted with Burmese migrant workers and refugees involving 581 TB patients; 70 per cent of whom successfully completed TB treatment.^[31] MSF provides voluntary counseling for HIV and testing for all TB patients and their families. If they are found to be HIV positive, MSF also supplies treatment and care for HIV which includes ARV therapy. This HIV/AIDS related support and ARV supply is different from the Thai government's NAAPHA project that receives separate funding. As of December 2008, MSF was providing free clinical care for approximately 169 TB/HIV co-infected patients and providing ARV therapy to 135 patients. MSF continues to provide ARV therapy even after TB has been cured. At the beginning, MSF services were extended to all illegal and cross-border Burmese migrant populations. However, MSF has since stopped providing clinical care and access to medication and support for cross border populations since August 2007.

One of the reasons the organization made the decision to stop including cross border patients in their services was due to a high rate of defaulters for TB medications and the difficulties associated with tracing such mobile patients. MSF is also limited in its capacity to address drug adherence challenges and patient follow-up with the treatment of cross-border populations. Moreover, there is a TB program running in Burma and Multi-Drug Resistant Tuberculosis (MDRTB) becomes a problem among displaced Burmese. This is evidenced by the 45 cases of MDRTB which MSF has identified. MSF also provides MDRTB treatment to those patients MSF is serving in the best interest of the displaced Burmese with HIV and TB, despite the many challenges.

MSF works principally in emergency and crisis situations worldwide. The issue of HIV/AIDS on Thai-Burma border is a chronic and on-going challenge and it is not within MSF's mandate to provide long-term treatment, care and support on the Thai-Burma border. As a result, MSF has decided to pull out from the Thai-Burma border by the end of year 2009. MSF will support the treatment of TB and HIV by supplying medication to patients in need until October 2009 for those currently on treatment. But, since March 2009, MSF has had no choice but to refuse treating newly diagnosed HIV cases that were diagnosed by other health organizations. At this time, MSF is preparing to permanently pull out from the border.

By the time MSF pulls out, TB patients who were receiving treatment from MSF will be covered by World Vision Foundation of Thailand (WV). But WV will not treat those patients with MDRTB. MSF Mae Sot attempted to implement a project providing treatment for Burmese migrants living with MDRTB. But the project was refused by the MSF head office. The head office argues that Thai authorities should take responsibility for these patients.

MSF is trying to hand over Burmese migrants living with HIV who are on ARV to the Mae Sot General Hospital. It is not an easy task; Mae Sot Hospital has reported they are very busy and over worked. This means that the Mae Sot Hospital must refuse to take on patients who are already on ARV provided by MSF. MSF knows that if certain NGOs can work toward addressing the ARV treatment adherence issue, then it is possible for ARV to be accessible for free through the expansion of NAPHA. MSF is still seeing a willing organization which can work in the best interest of those currently on ARV. Further, Burmese migrant workers who are receiving ARV from MSF are waiting for new NGOs to provide them with treatment, care and support.

(The content expressed here has been approved for publication by MSF Mae Sot office on 17 March 2009)

World Vision Foundation of Thailand

World Vision Foundation of Thailand (WV) is a charitable Christian development organization principally for poor children and their suffering families. WV in Mae Sot has received funding from the Global Fund (GF) and it is working on HIV and sexually transmitted infection (STI) related problems among Burmese migrants. It initiated regular STI check up programs for Burmese female sex workers by promoting access to health care services.

The WV promotes behavioral change communication (BCC) for Burmese migrant worker and Burmese sex workers. It distributes condoms to targeted communities, factories, and 9 brothel houses in Mae Sot through volunteers trained by WV, free condom boxes, training sessions, and community outreach activities. WV works closely with factory workers and community volunteers to promote HIV prevention and safe sex education among migrant communities. WV also organizes self-help groups in the migrant community to help create supportive psycho-social environments for migrants, especially for people living with HIV. The organization also initiates regular meetings and operates small income generation programs for Burmese migrants living with HIV/AIDS.

The WV understands food security issues that displaced Burmese people living with HIV/AIDS are faced with. It supplies staple food items for 50 Burmese migrants living with HIV (650-850 Baht/month which is about 22-28 CAD/month). Although, the real figure of Burmese migrants living with HIV is estimated to be much higher than the number receiving food aid since WV is limited by their funding.

Migrant volunteers trained by WV actively search for signs and symptoms of opportunistic infections and STI among displaced Burmese living with HIV/AIDS. If cases are identified they are subsequently referred to the Mae Sot General Hospital and Mae Tao Clinic. The WV provides directly observed therapy (DOT) treatment for migrant workers who have signs and symptoms of TB and who are sputum positive for TB. Since MSF has had to pull out from the Thai-Burma border, WV is now forced to treat migrants with TB who were previously under MSF's treatment and care. However, the WV TB program does not have the capacity to cover those migrants with MDRTB.

(The content expressed here has been approved for publication by World Vision Foundation of Thailand Mae Sot office on 8 March 2009)

Aide Médicale Internationale (A.M.I.)

Aide Médicale Internationale (A.M.I.) is a French humanitarian and apolitical non-governmental organization. AMI teams reinforce access to health care for people who are in need, in 9 countries.

AMI started working for Burmese refugee in 1995. On the Thai-Burma border AMI's main objectives are to reinforce access to health care for the people living in 3 refugee camps, Mae La, Nupo and Umpiem. The organization also works to train local health care personnel within the camps.

In addition to these activities, A.M.I. provides HIV prevention, care and support programs for people living with HIV/AIDS. AMI's HIV prevention programs include awareness meetings, volunteer screening and preventive care. Providence of antiretroviral (ARV) treatment for people living with HIV is also a part of AMI's care program.

For displaced Burmese people living with HIV/AIDS in Mae La, Umpiem and Nupoe camps, AMI provides free ARV clinical care and counseling (*please see map – 3*). As of March 2009, AMI was providing free ARV, clinical care and psycho-social support for 120 Burmese refugees who live in the aforementioned refugee camps. AMI supports projects for all family members affected by HIV/AIDS. These activities are financed by EuropeAid, HCR.

Along with AMI, other international organizations (like International Rescue Committee (IRC), American Refugee Committee (ARC), International Organization for Migration (IOM) and Shoklo Malaria Research Unit (SMRU) also provide some care and support services for displaced Burmese with HIV/AIDS in refugee camps, especially targeting pregnant women and refugees planning for resettlement overseas.

(The content expressed here has been approved for publication by AMI head offices in Paris, France and Mae Sot, Thailand on 3 May 2009)

Migrant Assistance Program (MAP)

The Migrant Assistance Program (MAP) is a non-profit organization based in Chiang Mai, Thailand, dedicated to helping ethnic migrants from Burma. MAP is an acknowledged leader among organizations working on migrant issues in Thailand and has received funding from The Global Fund to Fight AIDS, TB and Malaria as a part of the prevention of HIV/AIDS among Migrant Workers in Thailand Project (PHAMIT).^[36]

MAP realizes that Migrants in Thailand predominantly come from the neighboring countries of Myanmar (Burma), Cambodia and Lao PDR, and fill the low-paying "three D" jobs (dirty, dangerous and degrading).^[36] MAP also recognizes Migrants' vulnerability to HIV/AIDS is increased by a complex set of factors; which include structural barriers, such as language differences, the location of services, documentation, and concerns of arrest or harassment. These barriers hamper migrants' ability to access proper reproductive and general health services, including accessing condoms. MAP distributes HIV/AIDS related education materials and condoms to migrant factories in Mae Sot area.

The role of a community based organization in HIV/AIDS care

Given the chronic life cycle of HIV infection, the role of community-based organizations for Burmese migrants living with HIV/AIDS in Thailand is extremely important and urgent. The principal community-based organization and health care provider for Burmese migrants in Thailand is Mae Tao Clinic (MTC). The MTC is located on the Mae Sot, which is located on the Thai-Burma border in the Thai side. Services provided by the MTC will be explained in a succeeding chapter.

"This work was carried out with the aid of a grant from the International Development Research Centre, Ottawa, Canada."



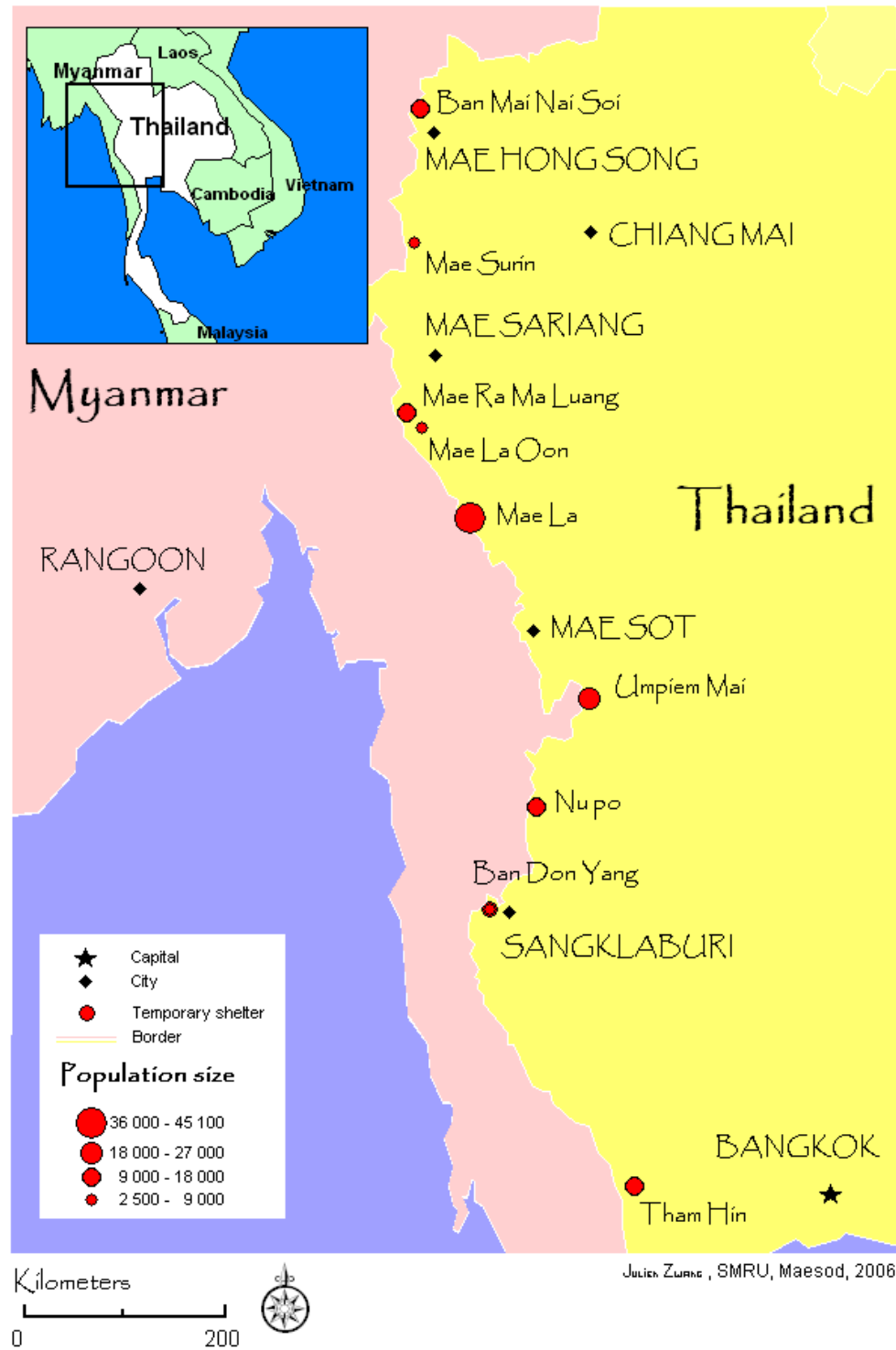
***Life is fun if we can forget our problems for a while;
Positive gathering in Mae Sot, displaced Burmese living with HIV/AIDS***

Table 1 - Organizations on the Thai-Burma Border Providing HIV/AIDS prevention and care for displaced Burmese (as of January 2009)

Organization	HIV/AIDS Services	HIV/AIDS cases
<u>International NGOs</u>		
1. Aide Medicale Internationale (AMI)	1. ARV supply and clinical care for those living in refugee camps 2. Voluntary counseling, testing and psychological support.	120-140
2. Migrant Action Programme (MAP)	1. Prevention of HIV/AIDS through Health Education for factory workers	-
3. Medecins Sans Frontieres (MSF)	1. ARV Treatment for those with active tuberculosis 2. Voluntary counseling and testing services for TB patients and their families	140-170
4. World Vision Foundation of Thailand	1. Psychosocial support and material support 2. Prevention of HIV/AIDS transmission through training and Behaviour Change Communication to migrants in the community, Factory Workers, and Sex Workers	50
<u>Thai Government Organization</u>		
5. Mae Sot General Hospital	1. ARV support for Burmese migrants with HIV 2. CD4 count, viral load and drug resistance testing	60 - 70
<u>Community Based Organization</u>		
6. Mae Tao Clinic	1. Voluntary counseling and testing 2. In-patient care 3. Out-patient care and follow up 4. Home based care 5. ARV supply through collaboration with Mae Sot hospital 6. Antenatal screening, care and prevention of Mother to Child Transmission 7. Social support 8. Income generation 9. Nutritional Supplement 10. Distribution of Home base care kits	250-300

Reference: Interview with corresponding organizations

Note: Some displaced Burmese living with HIV/AIDS in Thailand receive care and support from more than one health organization.



Map 3 – Map of the Thai-Burma border where displaced Burmese (refugees) are scattered
(Source: SMRU 2006)

THE MAE TAO CLINIC

The Mae Tao Clinic (MTC), founded and directed by Dr. Cynthia Maung, provides free health care for refugees, migrant workers, and other individuals who cross the border from Burma (Myanmar) to Thailand. People of all ethnicities and religions are welcome at this clinic. Its origins date back to the student pro-democracy movement in Burma in 1988. The brutal repression of this movement by the Burmese regime forced the students to flee from Burma (Myanmar). Some of them were in need of medical attention and were attended to in a small house in Mae Sot, Thailand.

Since 1989 the MTC has grown, from this small house to a large complex of simple buildings that provide a wide variety of health services to various groups of people. Today the clinic serves a target population of approximately 150,000 on the Thai-Burma border, although exact estimations are difficult to calculate due to the fluidity of this population. It is estimated that approximately 50% of those who come to the MTC for medical attention are migrant workers in the Mae Sot area. The remaining 50% travel across the border from Burma to receive care in Thailand.

The staff consists of five physicians, 140 health workers, and 100 support personnel who provide comprehensive health services including inpatient and outpatient care, surgery, blood transfusions, reproductive health, child health, eye care, and prosthetics for landmine and accident victims.



U.S. first lady Laura Bush, left, bids farewell to Dr. Cynthia Maung, at Mae Tao Clinic in Mae Sot near the Thai-Burma (Myanmar) border on Thursday, Aug. 7, 2008. (AP Photo/Apichart Weerawong)

The Mae Tao Clinic provides the following services for displaced Burmese:

1. Medical services

The clinic provides medical services for Burmese migrants in Thailand and for the thousands who come from Burma each year seeking medical assistance. They visit because there are a limited number of medical facilities in Burma and access is limited to existing facilities. Only a small fraction of Burma's national budget is invested in public health. Most of the Burmese migrants who live in the Mae Sot area are unable to receive health care other than at the MTC. This is due to the fact that they are unregistered and risk arrest or deportation at any given time. Those who do obtain employment often work in factories where they are paid very low wages that make it impossible for them to afford necessary medical services.

2. Social Services

Hospice and aged care: Patients often arrive at the MTC in need of hospice care. They commonly have AIDS, cancer, or are of an advanced age. The clinic provides support to these elderly persons who may have no family or friends to support them and if necessary, the clinic takes responsibility for their care until death.

Funeral and cremation services: Families of patients who die at Mae Tao Clinic may not be able to afford the cost of a funeral or for transporting the body back home. The clinic provides funds to either assist families to return the body home or conduct a small funeral at the MTC. The clinic collaborates with the Mae Sot Hospital when the managing the bodies of the deceased.

Support for amputees: The prosthetic department provides employment and rehabilitation services for amputees whose injuries make it difficult for them to find employment.

Cultural celebrations, sports events, and health campaigns: The clinic regularly organizes community events. Many of them are held during important, traditional festivals or holidays to recognize the importance of such events in strengthening community ties and providing a chance for friends and families to get together. In a situation where families are frequently separated and facing daily threats to their personal safety, these celebrations become very important for people's mental well-being.

3. Training

The Mae Tao clinic trains approximately 100 new health-care workers each year. The duration of the training program ranges from three months to two years. Some of the newly trained health practitioners remain at the clinic to work but the large majority leave to work in areas along the border with Burma (Myanmar). In-service medical training is provided for those engaged in health work. Workshops are also organized on social issues, such as human rights, women's rights, environmental health and other issues. Current training sessions at the MTC include, nursing care, laboratory skills, health assessments, maternal and child care methods, traditional birth attendant methods, basic eye care and computer training.

Border Internship Program: The MTC offers internships to health workers from different ethnic groups along the Thai-Burma border. Typically, interns complete their formal training of 4 to 5 years prior to their internship at various locations along the border. They then come to the clinic for 6-12-month blocks, to obtain departmental specific skills or to rotate through different departments at the clinic. After receiving their training at the MTC they can transfer their knowledge and skills to begin to better understand populations in vulnerable areas. In 2004, 60 interns from different ethnic health organizations completed a 6-month internship at the Mae Tao Clinic.

In addition to clinical practice and training services, the MTC offers a variety of programs geared towards community support and patient rehabilitation. The clinic is increasingly serving the role as a community centre, as the continual oppression of people living in Burma (Myanmar) creates a demand for additional healthcare services.

Awards received by Dr Cynthia

2008 - Catalonia International Prize, Spain, **2007** - Asia Democracy and Human Rights Award (Taiwan foundation for Democracy), **2007** - The World's Children's Prize for the Rights of the Child (WCPRC) (Sweden), **2005** - Nominated as part of the 1,000 Women Nobel Peace Prize Nomination (Global), **2005** - Unsung Heroes of Compassion Award from the Dalai Lama and Wisdom in Action (San Francisco USA), **2005** - The Eighth Global Concern for Human Life Award (Chou-Ta Kuan Foundation, Taiwan), **2005** - Included in Time Magazine's November Article on 18 Global Health Heroes, **2002** - Magsaysay Award for community leadership, Philippines, **2001** - Foundation for Human Rights in Asia Special Award, Japan, **2001** - Van Hueven Goedhart Award, the Netherlands, **1999** - Jonathon Mann Health and Human Rights Award, USA, **1999** - American Women's Medical Association President's Award, USA, **1999** - John Humphries Freedom Award, Canada.

4. Outreach

HIV education and prevention: The MTC annually train peer educators, the majority of whom are factory workers, to educate the community on how to prevent HIV and to distribute educational pamphlets. The MTC's HIV outreach program provides home visits to roughly 150 families that have a HIV positive family member who is too ill to travel to the clinic. The MTC also organizes a World AIDS Day campaign every year and each month a positive gathering is held for people living with HIV in the community.

Adolescent health education: The Mae Tao Clinic annually visits local migrant schools and conducts workshops for adolescents on teen health issues such as sex education, leadership skills, gender issues and HIV/AIDS. The Adolescent Reproductive Health Network Group in migrant areas has developed a training curriculum and exchanges information regularly with the MTC.

Migrant school health program: The School Health Program visits migrant schools twice a year to introduce prevention measures against vitamin A deficiency and worm infestations as well as to provide vision screening and health education. Teachers also receive training on school health curriculum development, which they include in their lessons.

5. Cross-Border Programs:

Primary health-care clinics: The Mae Tao Clinic maintains two primary health care outpatient and inpatient clinics for populations inside Burma (Myanmar) at Pa Hite in Mutraw District (population 14,000) and Ler Per Her in Pa-an District (population 2,000). These clinics are a part of the Karen Health and Welfare system and serve as patient referral centers. They also contain inpatient facilities for the Back Pack Health Worker Teams. Terrain in this area is mountainous and harsh with long rainy seasons, which makes malaria particularly prevalent. It is the most common health threat, but villagers in this area also suffer as a result of being displaced by military operations on average two times a year.

Child protection and education: In addition to the medical programs outlined, the clinic also promotes initiatives that improve the welfare of children.

Delivery certificates: A delivery certificate is issued for every birth at the Mae Tao Clinic. The MTC also collaborates with the Committee for Protection and Promotion of Child Rights (CPPCR) to raise awareness about stateless children and helps provide them with documentation.

Children's development centre: The clinic runs a school for children of migrant workers in Thailand. The children of the MTC staff also attend. In the school year 2007-2008, there were roughly 500 children attending. The school consists of a day care centre, nursery school, and primary school that goes up to 6th standard (grade 6). The school provides boarding accommodation for approximately 160 boarders.

"This work was carried out with the aid of a grant from the International Development Research Centre, Ottawa, Canada."

Another community based organization which closely works with the MTC is Social Action for Women (SAW).

6. Social and housing services (as SAW)

Bamboo children's home: The clinic supports one boarding house in the refugee camps for unaccompanied children. In 2006, there were around 140 children residing in this boarding house.

Orphan care: The clinic promotes the basic rights of children. Young migrant children are particularly vulnerable and open to the dangers of exploitation and trafficking. The clinic supports children who are orphaned or abandoned by their parents. Poverty is a major reason for the existence of so many orphans. In 2004, the clinic supported and cared for 21 orphans. Several other cases have been referred to the local Burmese women's organization, Social Action for Women (SAW), which has a program that cares for abandoned babies and children in the Mae Sot area. SAW is also a home for AIDS orphans.

Asylum for women and children: The clinic has a functioning drop-in shelter for people in need of a place to stay. People seeking protection and support from abusive relationships are frequently taken in at the clinic until safe alternative arrangements can be made for their accommodation.



"We do not know our citizenship status, we do not know who our parents are, we do not know what HIV infection is, but, we know that we have HIV"

6. Home Based Care Team

In November 2004, the director of the MTC noted that the worst problem facing individuals dying of AIDS is the lack of family available or willing to care for them. This deficiency served as the impetus for a special HIV care unit called the Home-based Care Team. All eight of its permanent staff members are HIV positive.

In January 2005, this team received specialized training from Family Health International. Since the completion of this training, the team considers themselves to be twice as effective.

What duties are performed by the Home-based care team?

- The staff provides newly diagnosed individuals with sensitive peer counseling. The counseling stems from team members' personal experiences and helps patients to feel less lonely.
- The staff assists family members of HIV positive individuals to seek employment and education.
- The staff understands the challenges of living with HIV and offers many helpful suggestions and methods to cope with discrimination and other obstacles.
- The staff visits individual homes to share advice and provide treatment as best as they can.
- They readily recognize danger signs in patients' conditions and make referrals to hospitals.
- At the hospital, the team visits and provides nursing care for patients who are terminally ill. They often have no family members to provide this type of support because they remain in Burma.
- The staff helps to organize and provide funerals for individuals, should they pass away without family to care for them.

The home-based care team encounters many obstacles but they are dedicated to helping displaced Burmese living with HIV/AIDS. It is very difficult to monitor people living with HIV along the border, as they are very mobile. Maintaining consistent contact with them is near impossible especially since the home-based care team members themselves are constantly at risk of deportation.

The team can provide care and psychosocial support but they are unable to provide anti-retroviral therapy or medications for opportunistic infections to displaced Burmese living with HIV/AIDS. Despite these obstacles, the team remains committed to its work. The home-based care team has a strong spirit and they are determined to continue their work as long as they are able. Their continued sacrifices are innumerable. We should offer our greatest respect and gratitude for their work.

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Home Based Care Teams can provide care and psychological support for displaced Burmese with AIDS, but they do not have access to anti-retroviral (ARV) or other medications for HIV.

IMPROVING SELF COPING SKILLS

Displaced Burmese living with HIV/AIDS suffer from the worst circumstances when they develop illness. Normally, they do not have a family to take care of them. They often get nursing care and psychological support from other HIV positive displaced Burmese. In November 2004, due to increased demand, the Mae Tao Clinic organized a group of people who were HIV positive to help other displaced Burmese living with HIV/AIDS. There are also volunteers and healthcare workers at the Mae Tao Clinic and international NGOs on the Thai-Burma border who are dedicated to providing care for displaced Burmese living with HIV/AIDS.

Acquiring ARV therapy for those infected with HIV is challenging as the border is a resource limited setting. In the Mae Sot area, there is one major hospital catering to those living with HIV/AIDS; however, even though there is Thai government-funded hospital, it only has the capacity to perform blood tests for a limited number of Burmese living with HIV/AIDS. In addition, the number of physicians dedicated to treating displaced Burmese living with HIV along the border is highly limited. Opportunistic infections are very common and are the leading cause of death for those living with HIV/AIDS. As such, HIV caregivers and those living with HIV should have stronger knowledge of ARV therapy and opportunistic infections. They need to understand how to interpret laboratory results and give the best advice to other displaced Burmese living with HIV/AIDS and their families.

The provision of HIV treatment and care trainings in resource-limited settings is improving rapidly in the other parts of the world; however, there are still very few training opportunities on the Thai-Burma border. Caregivers on the border need more training in the HIV/AIDS-related areas to increase their capacity. Such training will improve their skilled behaviors and care. Twenty-five years of international research, development, activism and patient engagement have provided an effective range of therapies and monitoring for HIV and the majority of related conditions. Caregivers on the Thai-Burma must have access to the most up-to-date information on HIV/AIDS related issues. Health-worker training is one of many factors critical to the rapid scale-up of high-quality HIV/AIDS care.

HIV Training sessions on Thai-Burma border

To educate the HIV healthcare providers on the border is urgently needed. There was a three-day training session at the Mae Tao Clinic on the Thai-Burma border implemented as a part of this project, in August and in December 2008. Home-based Care Team members and representatives of Burmese migrants living with HIV/AIDS attended the training. There were more than 30 trainees and it used centralized didactic training as the core training method.

This method of training was useful and appropriate in that the classroom style is a familiar approach for many trainees on the border; it requires fewer resources and allows for standardization of the training's content. The training included a review of HIV infection and AIDS, when and how to start ARV therapy, side effects of treatment and how health can be monitored by various blood tests. Due to time and financial constraints, some important topics like terminal care and details about opportunistic infections could not be covered during the training session.

All training materials were provided by the British Columbia Persons With AIDS (BCPWA) Society. BCPWA's power point presentations were translated into Burmese and were used as core training materials. Emphasis was made on information that was specific to those living on the border. HIV/AIDS caregivers on the Thai-Burma border deserve to have the latest HIV/AIDS information and they need more training on home-based care, control of opportunistic infections and sexually transmitted infections.

Output of training sessions

- Caregivers on the Thai Burma border understand more about HIV, ARV therapy and monitoring of health with blood work in people living with HIV/AIDS.
- Caregivers on the Thai-Burma border will be capable to work more effectively for the displaced Burmese population living with HIV/AIDS.
- Caregivers on the Thai-Burma border will be able to provide health education on HIV, ARV therapy and monitoring of health with blood work on the Thai-Burma border, which increases the community's capacity to help people living with HIV/AIDS.

"This work was carried out with the aid of a grant from the International Development Research Centre, Ottawa, Canada."



Health care providers and displaced Burmese with HIV/AIDS on the border should have accurate, reliable and easy-to-understand HIV/AIDS information

COMMUNITY CONSULTATION

As part of the mission of "Giving a Hand to Displaced Burmese Living with HIV/AIDS", a community consultation session was held on December 20th, 2008 at the Mae Tao Clinic (MTC) in Mae Sot, Thailand. The aim of this day-long community consultation session was:

1. To obtain an in-depth understanding of the problems encountered by displaced Burmese living with HIV/AIDS in Thailand.
2. To identify possible solutions for the identified problems from the community's perspective.
3. To improve the coordination and integration of the displaced Burmese community.

In light of the complex HIV/AIDS-related problems among displaced Burmese, community input was viewed as an important step of the health project implementation. In order to assure the community consultation was inclusive, useful and effective, the consultation process involved both displaced Burmese living with HIV/AIDS and HIV/AIDS service providers. Out of 40 participants in this consultation session, 24 were displaced Burmese living with HIV/AIDS in Thailand (60%), and 16 were HIV/AIDS service providers who were working on the Thai-Burma border (40%).

There were 3 consultation sessions which addressed 3 different topics. The first session was a discussion on the problems encountered by displaced Burmese living with HIV/AIDS on the Thai-Burma border. The second session was on the prevention of HIV transmission in the Burmese migrant community in Thailand. The last session focused on proposals for helping displaced Burmese living with HIV/AIDS in Thailand. Each session lasted approximately 2 hours which provided adequate time for discussion, interaction and idea generation among displaced Burmese living with HIV and HIV/AIDS service providers.

The participants were divided into 3 groups; the participant composition of the groups was similar as each group contained the same proportion of displaced Burmese living with HIV/AIDS (60%) and HIV/AIDS service providers (40%). Each group had a facilitator, with knowledge of and experience with the consultative process, and who proceeded to explain this process to their group members. The facilitators included one counselor from *Medecins Sans Frontieres* (MSF) and two counselors from the MTC. All facilitators were explained about consultation procedures prior the event.

Each group was directed to discuss and outline solutions for all three of the topics on the agenda; although groups could freely bring up additional topics, they were encouraged to stick to issues that were relevant to the discussion at hand and to the community at large, and were not simply peripheral topics. Participants could discuss freely but all discussion must be only for the sake of community, not for their personal profit or interest. Participants were provided lunch and snacks, which was funded by the International Development Research Centre (IDRC), Ottawa.

All participants were encouraged to provide input as to their viewpoints and each group was given the opportunity to propose their operational programs on the assigned topics. Subsequently, one representative from each group presented an explanation of their group's proposed program to all participants attending the consultation. Following feedback and evaluation by participants, final solutions on each topic were arrived at by all participants. The inputs and decisions from the community consultation sessions were incorporated into the recommendation section of this report.

The community consultation suggested the following points:

- HIV-positive community groups should commit to dealing with HIV/AIDS-related issues on the Thai-Burma border.
- HIV-positive community groups and other healthcare providers for displaced Burmese in Thailand should have adequate training to deal with identified issues.
- HIV-positive groups should carry out prevention programs for HIV, endeavor to reduce HIV/AIDS stigma, and engage in advocacy work for displaced Burmese living with HIV in Thailand.
- HIV-positive community groups should actively participate in the provision of care and support services for displaced Burmese living with HIV/AIDS.
- There should be income generation programs for displaced Burmese living with HIV/AIDS and their families.

In short, given the HIV/AIDS epidemic and associated problems on the Thai-Burma border, participants in the community consultation process voiced a need for efforts aimed at reducing HIV/AIDS stigma as well as a need for increased access to routine clinical care (including HIV medications) for displaced Burmese. Unfortunately, until the prevailing immigration problems with Thai police are resolved, and until international support and training for HIV-positive groups are increased, displaced Burmese in Thailand may not obtain the HIV/AIDS services they deem necessary. Please refer to the recommendation section of this report for a more detailed explanation on the problems and solutions that were identified through the community consultation process.

"This work was carried out with the aid of a grant from the International Development Research Centre, Ottawa, Canada."



"We have the best solutions for our problems; community consultation with displaced Burmese living with HIV/AIDS in Thailand, 20 December 2008"

INFORMATION, EDUCATION AND COMMUNICATION

Access to HIV/AIDS-related information is limited along the border. Though some pamphlets about HIV/AIDS are being distributed along the Thai-Burma border, they are mainly focused on prevention of HIV in the general migrant population. Historically, HIV prevention methods in a particular community have focused on persons who are not HIV-infected, to help them avoid becoming infected. However, further reduction of HIV transmission will require new strategies, including an increased emphasis on preventing transmission by HIV-infected persons aware of their status.^[18] This may be a highly cost-effective strategy in that prevention is targeted directly towards potential sources of new infection.

To provide more information to those living on the Thai-Burma border, two different types of pamphlets (1200 copies respectively) were distributed with support from the International Development Research Centre (IDRC). These pamphlets were directly translated from the British Columbia Persons With AIDS (BCPWA) Society and the Canadian AIDS Treatment Information Exchange's existing materials, with their approval. The first pamphlet pertains to the correct and consistent use of condoms, which aims to reduce further transmission of HIV from those who have already become infected. The second pamphlet is about women's health and prevention of mother-to-child transmission of HIV (PMTCT).

To date, no translated guidelines for positive living for displaced Burmese individuals living with HIV/AIDS in the border area have been developed. It would be helpful for displaced Burmese living with HIV/AIDS and their families if brochures focusing on ARV therapy, exercise and HIV, coping with stress, safe food/water and nutrition could be made available. These pamphlets are being developed; however, could not be published fully due to financial constraints. Distribution of the pamphlets is the most simple and effective way to improve the ability of people living with HIV/AIDS to cope with their social responsibilities, to empower them to make informed decisions about their lives, to encourage them to live positively and for them to die with dignity.

Output of pamphlet distribution on the Thai-Burma border:

- Displaced Burmese living with HIV/AIDS will understand their responsibilities and methods to prevent HIV to uninfected persons.
- Friends and families of displaced Burmese living with HIV/AIDS will understand more about women's health and prevention of mother-to-child transmission of HIV.
- Displaced Burmese living with HIV/AIDS will be capable of distributing HIV prevention information to other people living with HIV/AIDS and therefore increase community awareness.

ရောဂါပိုးတွေ မကူးစက်အောင် ဒါတွေကိုရှောင်ပါ

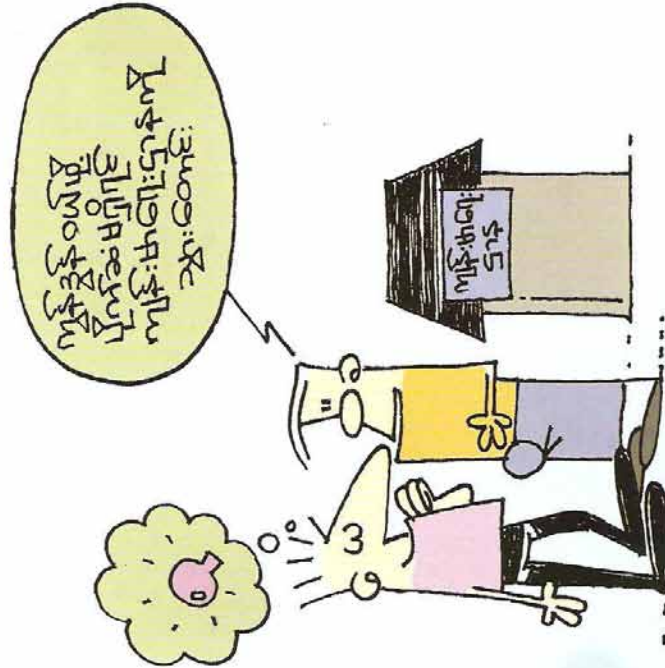
ခံထည့်ထားတဲ့ အိတ်ကိုဖောက်တဲ့နေရာမှာ ကတ်ကြေးကို မသုံးပါနဲ့။
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ယူအဆီ (Lubricant) နဲ့ တွဲဖက်ပြီး မသုံးပါနဲ့။
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မွေးတာဆေးတွေဟာ ကိုယ်ပေးခြင်းကို ကာကွယ်ပေးနိုင်ပေမယ့်
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ကုသကတ်တတ်တဲ့ရောဂါတွေကို မကာကွယ်ပေးနိုင်ပါဘူး။
ကွန်ဒိုမတို့ကို သုံးပြီးမှသာ အိတ်ဆုံဆုံနဲ့ရောဂါပိုး ကုသကတ်ခြင်းကို
ကာကွယ်ပေးနိုင်ပါတယ်။

ကွန်ဒိုမတို့နဲ့ပွဲစို့ကို အပြည့်အစုံရပါ

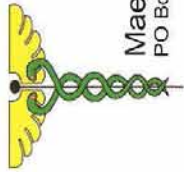
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လိမ့်မယ်။



ဒီစာစောင်မှာ ဖော်ပြထားတာတွေထက် ပိုပြီးသိလိုတာတွေရှိမယ်ဆိုရင်
မယ်တော်ဆေးခန်း၊ သွေးလျှောက်နဲ့ နှစ်သိမ့်ဆွေးနွေးကူညီရေးဌာနတို့ကို
ဆက်သွယ်နိုင်ပါတယ်။

သွေးလျှောက် (Blood Bank)
ph: 085 050 6223, 086 202 7106
နှစ်သိမ့်ဆွေးနွေးကူညီရေးဌာန (Counseling Center)
ph: 089 643 9296, 087 571 7295

Courtesy of British Columbia Persons with AIDS Society and
Canadian AIDS Treatment Information Exchange.
This work was carried out with the aid of a grant from the
International Development Research Center, Ottawa, Canada.



Mae Tao Clinic
PO Box 67, Mae Sot, Tak 63110, Thailand

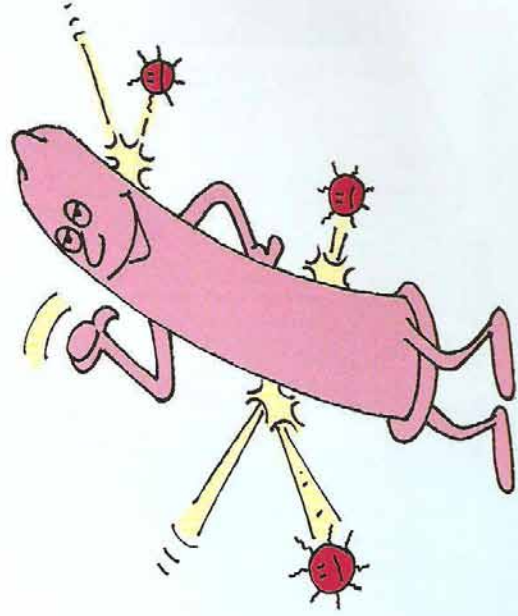
အမျိုးသားများလိင်ဆက်ဆံရာတွင် အသုံးပြုသည့်

ကွန်ဒိုမ လိင်တံစွပ်

ကွန်ဒိုမ (Condom) ဆိုတာ လိင်ဆက်ဆံချိန် ယောက်ျားအင်္ဂါမှာ စွပ်ပြီးသုံး
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ကွန်ဒိုမတို့ သုံးခြင်းအားဖြင့်

- အော့စတိုရီးအာက်စ် ခေါ် ရင်ဆေးကျဆင်းမှုရောဂါ ဖြစ်ပွားစေတဲ့ အိမ်ချိန်ဒိုမို
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- လိင်ဆက်ဆံခြင်းကာလဆင့် ကူးစက်တတ်တဲ့ အခြားရောဂါတွေ ကူးစက်
ပြန့်ပွားခြင်းမှလည်း အကာအကွယ်ပေးပါတယ်။
- ပဋိသန္ဓေရခြင်းကိုလည်း ကာကွယ်ပေးပါတယ်။

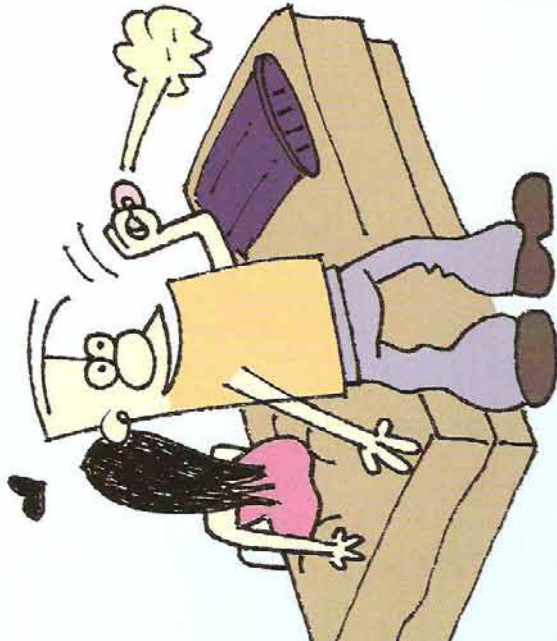


အမျိုးသား လိင်တံစွပ်

ကွန်ဒိုအသုံးပြုပုံ

လိင်ဆက်ဆံမှုပြုလုပ်တိုင်း ကွန်ဒိုကို အောက်ဖော်ပြပါအတိုင်း နေ့စဉ်တကျအသုံးပြုသင့်ပါတယ်။

- ကွန်ဒိုအိတ်ဖောက်ရာမှာ လက်သည်းတွေကြောင့် ကွန်ဒိုပေါက်ပြဲစေဖို့ သတိပြုပြီး ဖောက်ပါ။
- သင်၏လက်မကိုအသုံးပြုပြီး ကွန်ဒိုကို အတွင်းအပြင် ခွဲခြားဆုံးဖြတ်ပါ။ ကွန်ဒို၏ ဘေးအနား ရာဘာအလိပ်ဟာ အပြင်ဘက်မှာ ရှိပါမယ်။
- လိင်တံတင်းမာလာချိန်ရောက်မှ ကွန်ဒိုကိုစွပ်ပါ။
- ကွန်ဒိုရာဘာအလိပ်ကို မဖြေချင် ကွန်ဒိုခေါင်းပိုင်းမှာ လေမရှိစေဖို့ လက်မနှင့်လက်ညှိုးကို သုံးပြီး ညှစ်ထုတ်ပါ။
- ကွန်ဒိုအိတ်ကို ညှစ်ထားလျက်ကနေ ရာဘာအလိပ်ကို လိင်တံအရင်းပိုင်းသို့ ဖြေချပါ။
- လိင်ဆက်ဆံပြီးတဲ့အခါ ကွန်ဒိုထဲကအရည်တွေ မိတ်ဆင်ရအောင် သတိပြုပြီးတော့ လိင်တံအရင်းက ဝှိုးချွတ်ပါ။
- အသုံးပြုပြီးတဲ့ကွန်ဒိုကို နေ့စဉ်တကျစွန့်ပစ်ပါ (ဥပမာ - အနီကပ်ပုံထဲကို စွန့်ပစ်တာမျိုး လုပ်ပါ။)
- ကွန်ဒိုကို တကြိမ်ထက်ပိုပြီး အသုံးမပြုပါနဲ့။



ကွန်ဒိုအသုံးပြုတာနဲ့ ပတ်သက်လို့

သင့်ရဲ့လိင်ဆက်ဆံဖက်ကို ဒါတွေပြောပြပါ

- သင်၏လိင်ဆက်ဆံဖက်၊ ကွန်ဒိုအသုံးပြုပြီး လိင်ဆက်ဆံရတာ သိပ်ပြီး အရသာ မရှိဘူး။
- သင်ပြန်မြေသင့်သည်မှာ၊ ကွန်ဒိုမပါရင် လိင်ဆက်ဆံဖို့ ငါမိတ်မပါဘူး။ ဒါဆို ပိုပြီးတော့ အရသာ မရှိဘူး ဖြစ်သွားမှာပေါ့။
- သင်၏လိင်ဆက်ဆံဖက်၊ ရာဘာအစွပ်ကြီးက ရှုပ်ပါတယ်။
- သင်ပြန်မြေသင့်သည်မှာ၊ ကိုယ်ဝန်ရသွားရင် ပိုရှုပ်သွားမှာပေါ့။ အိပ်ချိုအိုင် ခွံပြီး ကူးသွားရင် လုံးဝကိုရှုပ်ကုန်ပြီ။
- သင်၏လိင်ဆက်ဆံဖက်၊ ငါ့ကို မယုံကြည်လို့ ကွန်ဒိုသုံးတာလား။
- သင်ပြန်မြေသင့်သည်မှာ၊ နင့်ကိုယုံပါတယ်။ ဒါပေမယ့် လူအများစုက သူတို့မှာ လိင်ကာဆင့်ကူးစက်တတ်တဲ့ရောဂါတွေ ရှိနေတာကို မသိကြဘူး။
- သင်၏လိင်ဆက်ဆံဖက်၊ တကယ်ချစ်လို့ ကွန်ဒိုသုံးတာလား။
- သင်ပြန်မြေသင့်သည်မှာ၊ တကယ်ချစ်ပါတယ်။ ဒါပေမယ့် ကွန်ဒိုမသုံးဘဲ လိင်ဆက်ဆံတဲ့နည်းနဲ့တော့ အချစ်ကို သက်သေမပြပါရစေနဲ့။



လိင်ဆက်ဆံရာကတဆင့် ရောဂါပိုးတွေ မကူးစက်အောင်

ဒါတွေကိုသင်ပါ

- လိင်ဆက်ဆံတိုင်း ကွန်ဒိုကိုအသုံးပြုပါ။
- အမျိုးသမီးရော၊ အမျိုးသားပါ ကွန်ဒိုအကြောင်းကို နားလည်သိရှိအောင် ကြိုးစားပါ။
- သင်အသုံးပြုသော ကွန်ဒိုသည် သက်တမ်းလွန် (Expire Date) ကွန်ဒို မဖြစ်စေရန် အမြဲသတိပြုပါ။
- ကွန်ဒိုကို အေးသောနေရာတွင် သိမ်းဆည်းပါ။
- အဆီအသင့်ပါပြီးသော ကွန်ဒိုကို အသုံးပြုပါ၊ ပြင်ပမှအဆီ (Lubricant) နှင့် တွဲဖက်အသုံးပြုပါက ကွန်ဒိုပေါက်ပြဲခြင်း ဖြစ်စေနိုင်သည်။
- ကွန်ဒိုကို သင်သွားလေရာ သယ်ဆောင်၍ အသင့်ရှိနေပါစေ။ ကွန်ဒိုကို ပိုက်ဆံအိတ်ထဲထည့်၍ ခါးကြားထိုးထားခြင်း၊ အိတ်ထဲတွင် သော့တွဲများ နှင့်အတူရောနှောသယ်ဆောင်ခြင်း မပြုလုပ်သင့်ပါ။ ကွန်ဒိုပေါက်ပြဲသွား နိုင်သည်။

ကျွန်တော်က အသက်ကြီးနေပါပြီ - များ



သင်၏တဝတခုလုံး ကျန်းမာရေးအတွက်

ကွန်ဒိုကို စနစ်တကျ အသုံးပြုပါ။

ကိုယ်ဝန်ဆောင်မိခင်မှ ရင်သွေးငယ်သို့

အိပ်ချ်အိုင်ဗွီပိုးကျူးစက်မှုနှုန်း

လျော့နည်းကျဆင်းစေသော အခြေအနေများ

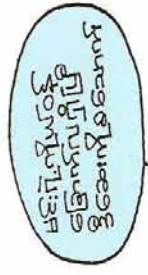
- သွေးထဲတွင် အိပ်ချ်အိုင်ဗွီရောဂါပိုး ပမာဏ (Viral Load) နည်းပါးခြင်း၊
- ဗီဒီနိုး (CD4) သွေးဖြူဥပမာဏ များပြားခြင်း။
- အေအာရီ (ARV) ခေါ် အိပ်ချ်အိုင်ဗွီပိုး တိုက်ဖျက်မှုကို ထိန်းချုပ်ပေးသော ဆေးဝါးများ ကိုယ်ဝန်ဆောင်စဉ် သောက်သုံးခြင်း။
- ဗိုက်ခွံ၌ မွေးဖွားခြင်း။
- ကိုယ်ဝန်ဆောင်စဉ် အိပ်ချ်အိုင်ဗွီရောဂါပိုးရှိသူတို့ ဖြစ်ပွားတတ်သော နောက်ဆက်တွဲရောဂါ (Opportunistic Infection) တို့မှ ကာကွယ်ခြင်း။
- ကိုယ်ဝန်ဆောင်စဉ် လိင်မှတစ်ဆင့် ကူးစက်တတ်သော ရောဂါများ (STI) ဖြစ်ပွားပါက လျင်မြန်စွာ ကုသမှုခံယူခြင်း။
- ကျန်းမာရေးဌာန၏ စနစ်တကျ လမ်းညွှန်စောင့်ရှောက်မှုကို ခံယူခြင်း။
- ရင်သွေးငယ်အား မိခင်နို့တိုက်ကျွေးခြင်းကို ရှောင်ရှားခြင်း။
- ရင်သွေးငယ်အား အေအာရီ ခေါ် အိပ်ချ်အိုင်ဗွီပိုး တိုက်ဖျက်မှုကို ထိန်းချုပ် ပေးသော ဆေးဝါးများ တိုက်ကျွေးခြင်း။



မိခင်မှ ရင်သွေးငယ်သို့

အိပ်ချ်အိုင်ဗွီပိုးကျူးစက်မှုလျော့နည်းသွားအောင်

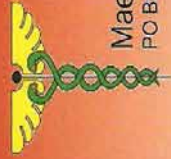
- အိပ်ချ်အိုင်ဗွီရောဂါပိုးတိုးပွားမှုကို နှောင့်နှေးရပ်တန့်သွားစေသော အေဇက်တီ (AZT- Zidovudine) ဆေးဝါးသည် ကိုယ်ဝန်ဆောင်မိခင်မှ ရင်သွေးငယ်သို့ ရောဂါပိုးကူးစက်ခြင်းများကို လျော့နည်းစေပါသည်။
- ကိုယ်ဝန်ဆောင်မိခင်အနေဖြင့် ကိုယ်ဝန်သက်တမ်း (၆) လမှစတင်၍ အေဇက်တီဆေးကို သောက်သုံးသင့်သည်။
- ရင်သွေးငယ်အား မီးဖွားပြီးစဉ်မှစ၍ အသက် (၆) လပြည့်သည်အထိ တိုက်ကျွေးသင့်သည်။
- အခြား အိပ်ချ်အိုင်ဗွီပိုးတိုးပွားမှုကို နှောင့်နှေးရပ်တန့်စေသော Nevirapine ကို မိခင်အား မီးဖွားစဉ်တွင် ကြိုက်၊ ရင်သွေးငယ်အား မီးဖွားပြီးစဉ်တွင် တိုက်ကျွေးခြင်းဖြင့်လည်း မိခင်မှ ရင်သွေးသို့ ရောဂါပိုး ကူးစက်မှုနှုန်းကို လျော့နည်းကျဆင်းစေပါသည်။



ဒီစာစောင်မှာ ဖော်ပြထားတာတွေထက် ပိုပြီး သိလိုတာတွေ ရှိမယ်ဆိုရင် မယ်တော်ဆေးခန်း၊ သွေးလျှောက်နဲ့ နှစ်သိမ့်ဆေးဓနွေကူညီရေးဌာနတို့ကို ဆက်သွယ်နိုင်ပါတယ်။

သွေးလျှောက် (Blood Bank)
 ph: 085 050 6223, 086 202 7106
 နှစ်သိမ့်ဆေးဓနွေကူညီရေးဌာန (Counseling Center)
 ph: 089 643 9296, 087 571 7295

Courtesy of British Columbia Persons with AIDS Society and Canadian AIDS Treatment Information Exchange.
 This work was carried out with the aid of a grant from the International Development Research Center, Ottawa, Canada.



Mae Tao Clinic
 PO Box 67, Mae Sot, Tak 63110, Thailand

အိပ်ချ်အိုင်ဗွီရောဂါပိုး နှင့် ကိုယ်ဝန်ဆောင်ခြင်း

- အိပ်ချ်အိုင်ဗွီရောဂါပိုးရှိနေသော အမျိုးသမီးများသည်
- ကိုယ်ဝန်ဆောင်ခြင်းအားဖြင့် အိပ်ချ်အိုင်ဗွီရောဂါအဆင့် လက္ခဏာ ပိုမိုဆိုးဝါးလာစဉ် မဟုတ်ပါ။
- အိပ်ချ်အိုင်ဗွီရောဂါပိုးကြောင့် သင်၏ကိုယ်ဝန်ဆောင် ကျန်းမာရေး ထိခိုက်မှုမရှိပါ။
- အိပ်ချ်အိုင်ဗွီရောဂါပိုး ရှိနေသော်လည်း ကျန်းမာသန့်ရှင်းသော ရင်သွေးငယ်ကို ရယူပိုင်ဆိုင်နိုင်ပါသည်။



အိပ်ချ်အိုင်ဗွီရပ်စ်ရောဂါဝိုးရိုးနေသော ကိုယ်ဝန်ဆောင်အမျိုးသမီးများအတွက်

အကြံပြုချက်

- အိပ်ချ်အိုင်ဗွီရပ်စ်ရောဂါဝိုးရိုးနေသော အမျိုးသမီးများသည်
- လိင်မှတစ်ဆင့်ကူးစက်တတ်သောရောဂါများ (STI) မကြာခဏ ဖြစ်ပေါ်ခံစားရနိုင်သည်။
- တကိုယ်ရည်သန်ရှင်းမှုကို အထူးဂရုပြုရန် လိုအပ်သည်။
- အာဟာရဓာတ်ပြည့်ဝအောင် စားသောက်ခြင်း၊ စိတ်သောက မိမိ၊ များ ကင်းမေးအောင် ရှောင်ရှားခြင်း၊ လုံလောက်စွာ အိပ်ခက်ခြင်း တို့ဖြင့် ခုခံအားကိုးမှုကောင်းမွန်အောင် တောင်ရွက်နိုင်သည်။
- ကျန်းမာရေးဝန်ထမ်းများ၊ နှစ်သိမ့်အားပေးမည့် မိတ်ဆွေအဖွဲ့အစည်းများဖြင့် အချိန်မှန်တွေ့ဆုံ ဆွေးနွေးသင့်ပါသည်။



မိမိရင်သွေးလယ်၏ အနာဂတ်အတွက် အကောင်းဆုံးဖြစ်အောင်ပြင်ဆင်ပါ။

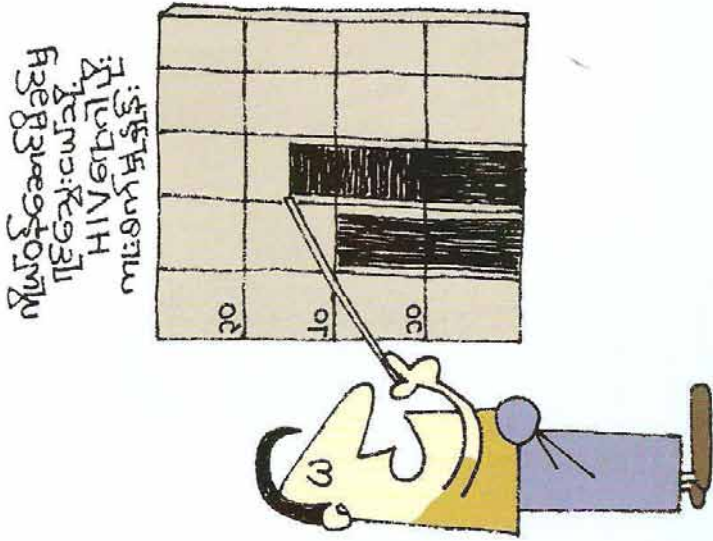
မိခင်မှ ရင်သွေးလယ်သို့

အိပ်ချ်အိုင်ဗွီရပ်စ်ရောဂါဝိုးရိုး

ကိုယ်ဝန်ဆောင်မိခင်မှ ရင်သွေးလယ်သို့ အိပ်ချ်အိုင်ဗွီရပ်စ်ရောဂါဝိုးကူးစက်မှုနှုန်းမှာ ၂၀ မှ ၅၀ ရာခိုင်နှုန်း (၅ ဦးအတွက် တဦးခန့်) အထိရှိနိုင်ပါသည်။

အောက်ပါအချိန်တို့တွင် ရင်သွေးလယ်သို့ အိပ်ချ်အိုင်ဗွီရပ်စ်ရောဂါဝိုးကူးစက်နိုင်သည်။

- ကိုယ်ဝန်ဆောင်စဉ်ကာလ (အထူးသဖြင့် ကိုယ်ဝန် (၆) လ နောက်ပိုင်း)
- မီးဖွားစဉ်ကာလ
- မိခင်နို့တိုက်ကျွေးစဉ်ကာလ



ကိုယ်ဝန်ဆောင်မိခင်မှ ရင်သွေးလယ်သို့

အိပ်ချ်အိုင်ဗွီရပ်စ်ရောဂါဝိုးကူးစက်မှုနှုန်း ပိုမိုမြင့်မားစေသော အခြေအနေများ

- သွေးထဲတွင် အိပ်ချ်အိုင်ဗွီရပ်စ်ဗီယာကာ (Viral Load) များပြားခြင်း၊
- စီဒီ၄ (CD4) သွေးဗျူဥ ဗီယာကာ နည်းပါးခြင်း။
- ကိုယ်ဝန်ဆောင်စဉ် မိခင်၌ လိင်မှတစ်ဆင့် ကူးစက်တတ်သော ရောဂါများ ဖြစ်ပွားနေခြင်း (ဥပမာ - လိင်အင်္ဂါရောဂါ)။
- ကိုယ်ဝန်ဆောင်စဉ် အရက်၊ ဆေးလိပ်သောက်သုံးခြင်း၊ မူးယစ်ဆေးဝါး သုံးစွဲခြင်း။
- မီးဖွားမီ (၄) နာရီထက်ပိုစောပြီး ရေမွှောပေါက်ခြင်း။
- ကော်ဗဲစွာ မီးဖွားခြင်း၊ ဟွဉ်းကိရိယာများ အကုန်အညီဖြင့် မီးဖွားခြင်း (ဥပမာ - ညှပ်ဆွဲမွေးခြင်း)။
- ရင်သွေးလယ်အား မိခင်နို့တိုက်ကျွေးခြင်း။



အပြစ်ကင်းစင်သော သင်၏ ရင်သွေးလယ်အား အိပ်ချ်အိုင်ဗွီရပ်စ်ရောဂါဝိုးကူးစက်ရန် သတိပြုဆင်ခြင်ပါ။

HEALTH RELATED QUALITY OF LIFE RESEARCH FINDINGS

Introduction

Every day the Thai-Burma border is flooded by Burmese migrants. It is estimated that there are more than 2,000,000 Burmese migrant workers in Thailand;^[17, 37] at least 1.5 million Burmese are displaced along the border areas.^[16] Thailand is seen as the land of opportunity for many of Burmese when they are living in economic depression and political oppression in Burma.^[1] However this is not true in real life. Burmese migrants in Thailand are not afforded adequate protection status or support to meet their basic survival needs. Migrants often face serious obstacles to good health due to discrimination, language and cultural barriers, legal status and other economic and social difficulties.^[1, 37] Drug related crime, sexual abuse and human trafficking problems are very common on the Thai-Burma border. All these factors contribute to Burmese migrants in the border area being highly vulnerable to infectious diseases including HIV/AIDS, though the number of new annual HIV infections in Thailand continues to decline.^[54] Between April 2003 and March 2005, 20% of Burmese migrants who had received Voluntary Counseling and Testing services at the Thai-Burma border were found to be HIV-positive.^[60] HIV/AIDS care and support works are more complex and more chronic than any other diseases; putting a disproportionately heavy strain on migrant health care services in border areas.^[24] There are very few training opportunities or care and support programs for displaced Burmese living with HIV/AIDS. As a result, displaced Burmese with HIV/AIDS in Thailand are living under terrible circumstances in severely marginalized conditions.^[17, 36]

Quality of life assessment is a standard measure of outcomes in clinical trials, cost effectiveness analysis and clinical practice.^[5] In the new HIV era, advances in drug therapy and the use of Highly Active Antiretroviral Therapy (HAART) have dramatically extend the life expectancy of people living with HIV/AIDS in developed countries. Still, these people report a lower health related quality of life (HR-QoL) than those with other chronic conditions, such as cancer or depression.^[13] In addition to treatment issues, psychosocial, sociodemographic, and psychological factors can affect Health Related Quality of Life (HR-QoL) in HIV-infected patients.^[12] Moreover, most of displaced Burmese in Thailand have to encounter immigration, cultural and language problems.^[1, 23, 71] As a result of this, they must have a much lower quality of life than any other people with HIV in the other parts of the world. Limited social support in a foreign country and poor coping skills are other factors which negatively affect health related quality of life in this population.^[11] It is important to understand the quality of life of displaced Burmese living with HIV/AIDS and realize which problems displaced Burmese with HIV/AIDS encounter most often. It is imperative to know the most efficient ways of helping these people to better cope with daily problems.

The number of peoples diagnosed with HIV increases everyday along the Thai-Burma border. HIV/AIDS has been a major problem for health care settings on the Thai-Burma border for many years.^[24] HIV is an infection mostly transmitted through unprotected sex worldwide. Initial reporting of identified AIDS cases among men who have sex with men (MSM),^[21] eventually labeling this epidemic as a sexually transmitted infection.^[54] Sexually transmitted infections (STI) dramatically increase the rate of HIV transmission.^[66] Asymptomatic STI are more common in women. In Thailand, more than four in 10 new infections in 2005 were among women, the majority of whom acquired HIV from husbands or partners, who had been infected either during unsafe paid sex or through injection drug use.^[54] A high prevalence of gonorrhea and chlamydia are found among asymptomatic HIV-infected MSM. There have also been recent studies showing an increases in HIV prevalence among MSM population^[54]

STI cause micro-abrasions in the genital area which makes transmission of HIV infection possible. Moreover, STI in HIV positive individual increases HIV viral load which in turn fosters the rate of HIV transmission. It was found that two thirds of syphilis cases diagnosed in HIV-infected patients had a dramatic effect in decreasing the CD4+ cell count and increasing the HIV viral load.^[39] One thing we can do to minimize the spread of HIV infection is to control transmission of STI. Improved treatment of STI leads to reductions in the incidence of HIV infection.^[21] However, the greatest challenges to global control of the epidemic is the lack of reliable evidence, particularly data on HIV and sexually transmitted infections as well as the prevalence and distribution of behaviors that contribute to the spread of the epidemic from resource-limited countries.^[61] Migrants in Thailand are particularly vulnerable to STI/HIV because they are excluded from general health information and have limited access to treatment for STI.^[71] Like everywhere in the world, STI and HIV transmissions are important issue along the Thai-Burma border. It is important to know more about sexual behaviors and the prevalence of STI among displaced Burmese living with HIV/AIDS. Only then, can we implement effective interventions for prevention of HIV transmission along the border.

Besides, there are so many factors which enhance the infection rate of STI and therefore the transmissions rate of HIV infection on the border. Changes in sexual behaviors, living under stressful situations and being away from family and relatives may be the most important. Some studies show that there is a significant lack of knowledge about HIV in the general Burmese population in the border areas.^[34] But no study has been conducted on knowledge, practices and attitudes (KAP) of displaced Burmese living with HIV/AIDS, which are exceptionally influential factors to regarding HIV transmission dynamic along the border. One study indicates that general knowledge concerning mode of transmission and prevention of HIV infection are good, however, this knowledge had not been applied to personal life circumstances in such a way that would facilitate avoidance of HIV infection.^[28] It is clear that the KAP of the general Burmese population on Burmese population on border areas plays a decisive role for the transmission and further spread of HIV infection. More importantly, the KAP of displaced Burmese currently living with HIV/AIDS also play a major role. Therefore, it is crucial to know more overall about the knowledge, attitudes and practices of displaced Burmese, especially those living with HIV/AIDS.

Aim

The aims of this study were:

1. To improve quality of life and reduce the impact of HIV on displaced Burmese living with HIV/AIDS.
2. To reduce transmission of HIV among displaced Burmese workers living in Thailand.

Objectives

The objectives of this study were;

1. To assess health related quality of life (HR-QoL) in displaced Burmese living with HIV/AIDS
2. To identify the types of sexual behaviors and prevalence of STI among displaced Burmese living with HIV/AIDS
3. To determine the knowledge, attitudes and practices (KAP) of displaced Burmese living with HIV/AIDS

Methods

Study Design: This project is a cross-sectional study of HIV-positive Burmese persons accessing care at a clinic in Mae Sot, Thailand. Participants were eligible if they were ≥ 18 years old and HIV-positive. Ethnicity was based on self-identification as being Burmese or other ethnic origins.

The goal of the study is to assess health-related quality of life, sexual behaviors, depression, stigma, and Knowledge, Attitudes and Practices (KAP) of Burmese people living with HIV/AIDS. An interviewer-administered survey collected information concerning demographics, stigma, depression, neighborhoods satisfaction, food security, medical and sexually transmitted infections (STI) history and quality of life. Clinical data regarding patients' STI history was obtained from Mae Tao Clinic (MTC) medical records. Interviews were performed in the language of the participant in private locations and took approximately 50 minutes to complete.

Target Population and Sample Size: The target population was HIV-positive Burmese migrant workers who are living in Thailand. The study enrolled both legal (registered) and illegal (unregistered) migrants with HIV/AIDS. Total of 150 Burmese migrants with HIV in Thailand participated in this study.

Due to the fluidity of this population, random sampling was not feasible. Participation was on a volunteer basis, with people being recruited and interviewed at the MTC, which is located close to the Thai-Burma border, in Thailand. 150 Thai Baht (about 5 CAD) honorarium was provided to all the participants upon completion of the interview.

Interviewers: The interviewers for this study were staff and volunteers from MTC. There were total of 4 interviewers assigned to interview on different days. Prior to conducting interviews, the clinic staff that volunteered to interview, were trained about the importance of informed consent and how to coach the participants without influencing their answers. A lengthy information session about the questionnaire was conducted with the interviewers to ensure that the interviewers had a clear understanding of the questions being asked. To make people feel more comfortable, female interviewers interviewed female participants and male interviewers interviewed male participants. Participants were encouraged to be as accurate as possible when answering questions.

Eligibility: Participants were eligible if they were ≥ 18 years old, HIV-positive and identified as being from Burma/Myanmar. The study did not accept surrogate interviewees and people with clinical AIDS cases were excluded for health reasons. Clinical HIV staging was assessed by physicians and nurses at MTC, according to WHO clinical staging of AIDS.

Definition of HIV positive: The Mae Tao Clinic (MTC), Medecins Sans Frontieres (MSF), World Vision Foundation of Thailand (WV) and Aide Médicale Internationale (AMI) offer voluntary counseling and testing for HIV (VCT) services for Burmese migrants. Regardless where the test is taken however, all positive blood samples are sent to Mae Sot General Hospital (MSGH) for confirmation by an ELISA test.

Recruitment Activities: Participants were recruited through research staff and physicians at the MTC and through word-of-mouth at various HIV/AIDS service organizations throughout the region. The voluntary counseling and testing for HIV (VCT) department at the MTC provides clinical care and social support for Burmese migrants in Thailand who are living with HIV/AIDS. The study team interviewed displaced Burmese living with HIV/AIDS during their regular visit for medical consultation at MTC.

Ethical Consideration: The study tool (questionnaire) and project proposal were approved by the Research Ethics Board at Simon Fraser University on June 27, 2008 (Attached). The clinic's HIV/AIDS counselors discussed the study and the consent form with participants before consenting the individual.

Confidentiality: Participant names were not recorded. All the questionnaires were coded with an unidentifiable number. Only the program manager at MTC had access to those codes. Study records are stored and locked at VCT department in the Mae Tao Clinic.

Instruments: To assess the quality of life in displaced Burmese living with HIV/AIDS in Thailand, we used World Health Organization, HIV/AIDS Quality of Life (WHOQOL HIV) instrument. This instrument has good psychometric properties and good discriminant validity.^[70] WHOQOL HIV instrument is also proved good to use for quality of life assessment for people living with HIV/AIDS in diverse cultural settings.^[70] For assessing depressive symptoms, 10-item Centre for Epidemiological Studies – Depression (CES-D 10) scale was used. Responses are scored from 0 to 3 based on the reported frequency of experiencing the symptom and summed to give the overall score, with a score of ≥ 10 considered depressed.

Food security level was assessed using the Radimer/Cornell measures. This measure separate level of food security with the frequency the participant experience certain situations as "often true", "sometimes true", or "never true". The Radimer/Cornell instrument has been shown to have good construct and criterion-related validity.^[19]

The questionnaire was developed by a research team at the British Columbia Centre for Excellence in HIV/AIDS (BCCfE), based in Vancouver, BC in Canada. The questionnaire is composed of more than 100 questions and takes on average 50 minutes to complete.

The questionnaires were targeted to seek answers in three main areas; HRQOL, sexual practices, and knowledge, attitudes and practices concerning HIV/AIDS. They were modeled after existing HIV/AIDS health related quality of assessment papers, and divided into 10 main sections. These included Demographic questions, Drug and Alcohol Use, Current Living Conditions, Past/Current Medical Problems, Stigma, Discrimination and Self Perception, Disclosure, Knowledge, Practice and Attitude towards HIV infections, Sexual Practice and History of Sexually Transmitted Infections, Care and Support Provided and Additional Care and Support in Need. Some questions were modified to be more locally appropriate and culturally specific.

All the data collected were transferred electronically to the BCCfE in Vancouver. Additionally, the clinic counselors reviewed medical records of participants who had positive STI history. The research team was given consent by participants to review the charts.

Data Analysis: Data analysis was carried out at the British Columbia Centre for Excellence in HIV/AIDS, Vancouver BC, Canada. SPSS 16 was used to design the questionnaire, customize the data entry process, and enter the data. The same program was used for conducting descriptive and inferential statistics. For continuous variables, numbers were entered as indicated by the participants (e.g. number of years for age) while code numbers will be allocated for categorical variables (e.g. sex: 1=female; 2=male). Multiple answers were allowed for open-ended questions. For topics of specific interest, such as to determine risk behaviors of those who indicated multiple/anal sex, answers given in the respective individual questionnaires were analyzed manually in detail.

The categorical variables were compared using Fisher's Exact Test and continuous variables were compared using the Wilcoxon Rank-Sum Test. For HIV knowledge answer, we divided the responses into three groups; right answers, wrong answers and do not know answers. Sample HIV knowledge questions are –

- A person can get HIV by sharing a glass of water with someone who has HIV
- A woman can get HIV if she has anal sex with a man
- People who have been infected with HIV quickly show serious signs of being infected
- There is a vaccine that can stop adults from getting HIV
- A person can get HIV by sitting in a hot tub or a swimming pool with a person who has HIV
- A person can get HIV from oral sex

Those who answered these questions correctly are in 'right answer group'; those who answered incorrectly are in 'wrong answer group' and those who respond as 'do not know' or do not respond are in 'do not know group'.

Limitations of the study: It is important to note that there was a limited sample size and participants were recruited at the MTC and therefore only those receiving medical care or social support from the MTC participated in research. There may be an HIV-positive Burmese migrant population who does not receive any care or support from MTC. Due to these limitations we cannot assume these results to be representative of all Burmese migrant workers who are living with HIV in Thailand.

Results

Of 150 people interviewed, 62 (41.3%) are male and the median age is 34 (Interquartile range (IQR): 29,38). 140 (93%) participants report being heterosexual and 94 (63%) were diagnosed with HIV after 2006 with 55 (37%) tested for HIV between 1996 and 2006. 124 (83%) people received HIV testing services at the Mae Tao Clinic and the rest received voluntary counseling and testing for HIV (VCT) services from other NGOs, public and private health centers. 46 (31%) respondents were tested because of a doctors' recommendation and 46 (31%) received an HIV test as part of a pre-natal screening program during pregnancy. 58 (39%) got HIV tests because of other reasons including personal decision.

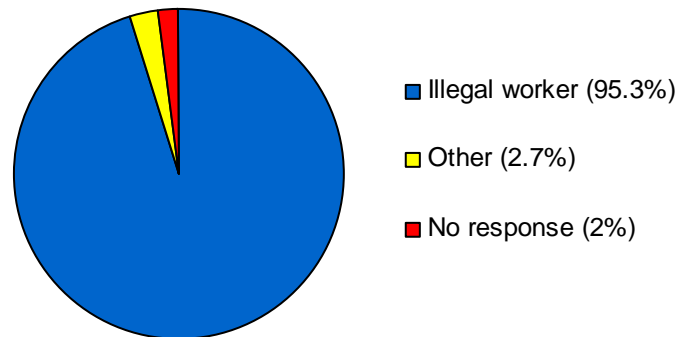
Median self reported CD4 count was 204/mm³. There were 59 (39%) that reported being on antiretroviral therapy (ARV) medications. In Canada, once patients reach a CD4 count of below 350 c/mm³ they are considered for medication. The majority of participants (96%) reported receiving regular medical care. Approximately three-quarters of respondents received medical care at the Mae Tao Clinic and the rest received HIV care at international and national NGOs and at the Thai government hospital.

A small number of respondents (5%) reported having health insurance. Normally, Thailand health insurance is issued to workers who have legal working permits. It is possible that some Thai business owners provided health care services for their factory workers and respondents reported that coverage as health insurance. 95% of displaced Burmese living with HIV/AIDS does not have any kind of health coverage.

The largest ethnic group of study participants is from Mon State (23%). People from Bago division represent the second largest group (20%), followed by people from the Yangon division of lower Burma (19%), and people from Kayin State (16%). The general education level is low with only 36% of participants reporting secondary school or higher.

When we asked about immigration status in Thailand, most people (95%) said they did not have legal immigration status in Thailand. 3% reported other immigration status, which was not specifically mentioned. The remaining few refused to answer questions about their immigration status in Thailand. Approximately two-thirds of participants (63%) migrated to Thailand after 2001. The rest remaining 37% migrated to Thailand between 1975 and 2000.

Figure 7 – Immigration status of displaced Burmese living with HIV/AIDS in Thailand



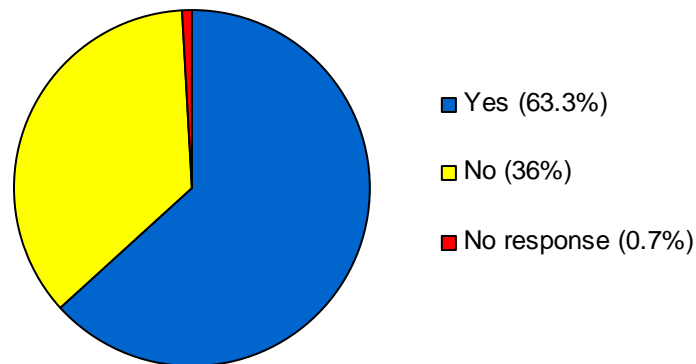
The most common mode of travel across the border from Burma to Thailand is by foot. 81% migrated into Thailand on foot and 13% had been arranged by third party to be able to migrate, which may be interpreted as smuggling. 66% of participants reported that they had crossed the Thai-Burma border more than once.

Figure 8 – Reasons for migrating to Thailand



For 40% of Burmese migrants, the major reason for leaving Burma for Thailand was to find a job. 21% migrated into Thailand to get health care. As stated earlier, 95% of displaced Burmese with HIV/AIDS in Thailand did not have any immigration status in Thailand. Consequently, 63% of respondents reported incarceration by Thai police at least once since arriving in Thailand and 42% had been deported back to Burma at least once.

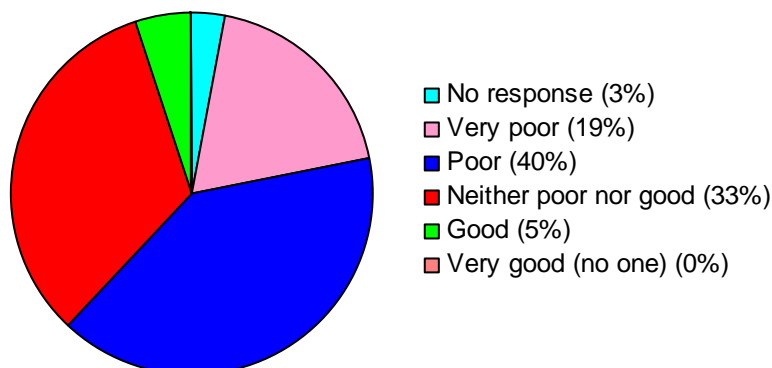
Figure 9 – Number of respondents who have been incarcerated by the Thai police



When asked about psychological and physical safety living in Thailand, 33% responded that they felt very safe to living in Thailand, 19% said they felt relatively safe and 27% responded they felt a bit unsafe living in Thailand. Only 21% (31 out of 150) reported they did not feel safe at all living in Thailand.

In response to how good is your quality of life question, only 1 participant answered that their quality of life is good. About 33% of participants answered that their quality of life was neither poor nor good. More than half of the participants (53%) reported that their life quality was poor. Moreover, 15% reported that they were living in a totally unhealthy environment and only 58% of participants reported that they were able to concentrate on things in their daily lives.

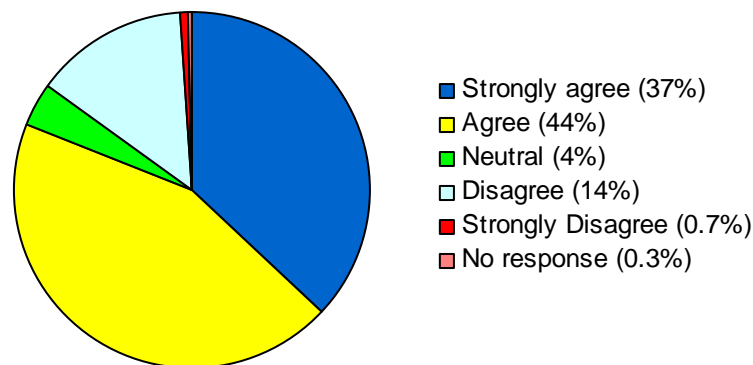
Figure 10 – Self-reported quality of life



Self-reported stigma related to HIV is high among the migrant workers. Over half (55%) of the participants reported that they have lost friends by disclosing their HIV status. 47% of participants answered that people treated them differently after learning the individuals' HIV status and that they have been hurt by that reaction. Many participants (47%) stopped socializing with their friends because of the reactions towards people living with HIV. Many participants (62%) worried that people who knew their HIV status would tell others, while 48% reported that are very careful whom they tell about their HIV status.

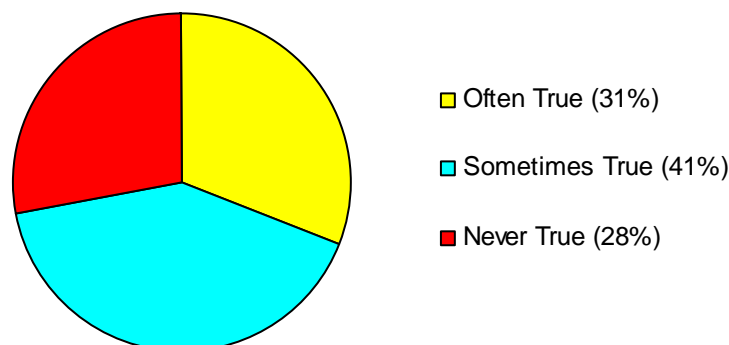
In terms of body image, 55% of people perceive themselves as bad persons because of their HIV status, 76% felt that they were not as good as others and 72% reported that they were unclean because of HIV infection. More than three-quarters (79%) of respondents believe other people think HIV is disgusting, 81% believe most people with HIV are rejected. The median overall stigma score was 36 on a 50-point scale (IQR: 30-40) signaling that this cohort feels highly stigmatized.

Figure 11 - Percentage of respondents who believe most people living with HIV are rejected when others learn their status



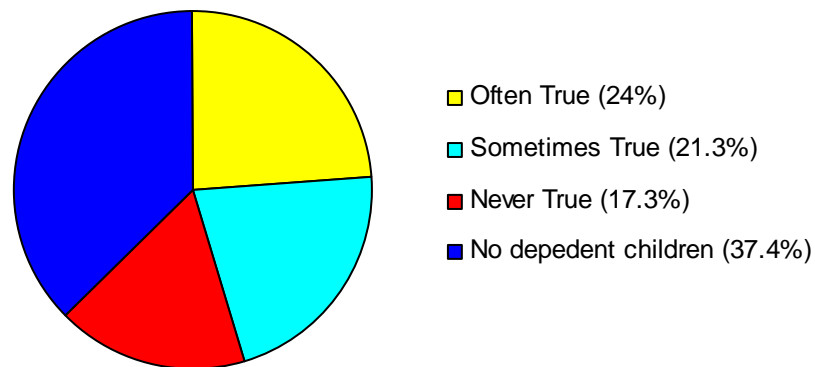
Using the food security scale, half of the participants reported often worrying that their food would run out before they got money to buy more, 47% reported the food they bought did not last often and they did not have money to get more, 49% reported they could not afford to eat properly, 38% reported they often ran out of food and not have money to get more, 31% reported they were often hungry but they did not eat because they could not afford food and 38% reported suffering hunger pains in the past year, but they could not eat because they couldn't afford food.

Figure 12 – Percentage of displaced Burmese who were often hungry, but could not afford to buy food



Almost one-quarter (23%) of respondents said their children were not eating enough because they could not afford enough food. 24% of participants reported knowing their children were hungry, but they could not afford more food. Many participants (23%) reported they could not afford to feed their children a balanced meal.

Figure 13 – I know my children were hungry, but I just could not afford more food



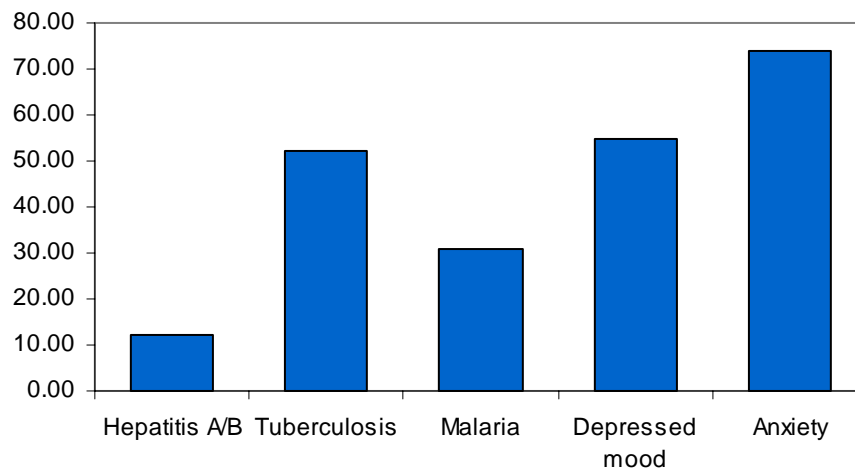
We also asked participants about their HIV/AIDS knowledge. The questions tested individuals' understanding of HIV transmission. The Knowledge, Attitudes and Practices section was comprised of 18 different. The answers were then categorized into 3 different sets, those who answered correctly, those who answered incorrectly and those who were unsure. 65% responded correctly, 14% responded incorrectly and 20% were unsure about whether they have knowledge to corresponding questions or not.

Figure 14 – HIV/AIDS knowledge of displaced Burmese living with HIV/AIDS in Thailand



37% of participants reported that they had suffered from depression and 49% reported that they often experiences symptoms of anxiety. From our preliminary data it is apparent that depression and anxiety are a problem among the HIV-positive Burmese population living in Thailand. In contrast to psychological problems, self report illicit drug use is extremely low among displaced Burmese living with HIV/AIDS. Only 1% (2 out of 150) reported that they had used Yaba (psycho stimulants) and another 1% (2 out of 150) reported having history of intravenous heroin injection.

Figure 15 – Self-reported medical history



Concerning the marital status of respondents, only 53% (80 out of 150) were married at the time of the interview. When we asked about sexual behaviors, most respondents (73%) refused to answer. It is therefore difficult to assess sexual behaviors in this population, but most of those that responded to the sexual behavior questions reported that on average they had 1-3 times per week. Interestingly, 18% of respondents reported that they had exchanged sex for money/food/drugs/housing.

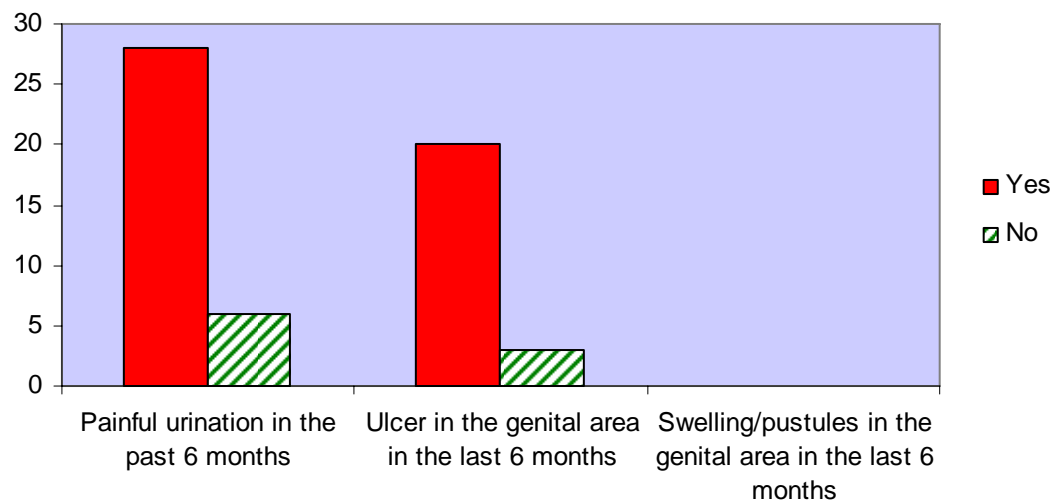
Sexually transmitted infections (STI) have long been known to increase the risk of HIV transmission. The questionnaire included questions about symptoms suggestive of STI such as painful urination, ulcers around genital area and swelling/pustule around genital area. 23% of people reported that they have experienced painful urination, 16% reported suffering from ulcers around genital area and 7% reported they had experienced swelling/pustules in the genital area.

Figure 16 – Number of displaced Burmese living with HIV who reported having symptoms suggestive of Sexually Transmitted Infections (STI) in their lifetime



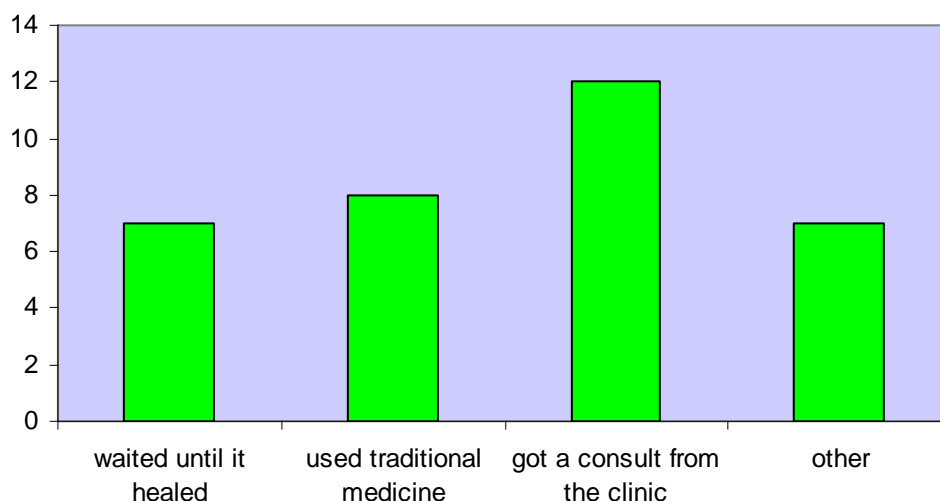
When we asked about above STI symptoms in the last 6 months, 19% reported episodes of painful urination and 13% reported having ulcers in the genital area in the last 6 months. Many of the participants chose not to respond to the questions.

Figure 17 – Displaced Burmese reporting symptoms suggestive of Sexually Transmitted Infections (STI) during the past 6 months



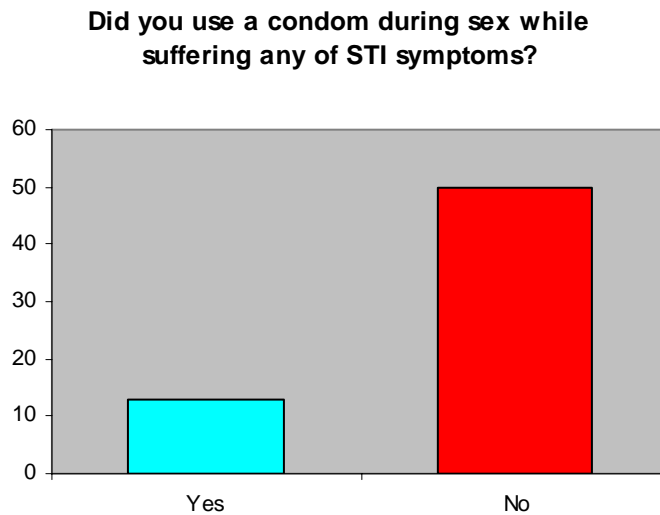
With the consent of the patients, we tried to confirm diagnoses of STI symptoms by reviewing the Mae Tao Clinic medical records. However, we could not get accurate diagnoses because of inaccurate diagnoses during the initial clinical examination and difficulty retrieving the patients' medical charts. At this time, only symptoms suggestive of STI can be reported. Participants were asked about how they managed their symptoms. Only 34 participants responded and among those only 35% reported seeking medical care at a health centre or clinic.

Figure 18 – Treatment for symptoms suggestive of Sexually Transmitted Infections (STI)



When asked whether they had used condoms during sexual intercourse while they were having symptoms suggestive of STI, only 65 participants responded to the question. 77% of the respondents said they did not use condoms while experiencing symptoms suggestive of STI.

Figure 19 – Number of displaced Burmese living with HIV who use condom during sex while suffering from symptoms suggestive of Sexually Transmitted Infections (STI)



When asked about condom availability, 46% reported that they get condoms from a free clinic 20% get them from NGOs and 1% said they get them from other resources such as the commercial market. 33% did not respond to the question.

28% participants reported that, in the past, they have not used condoms because they did not have any and 5% said they did not use condoms because they don't like them. 36% did not give any reasons for not using condoms.

Figure 20 – Reasons for not using condoms

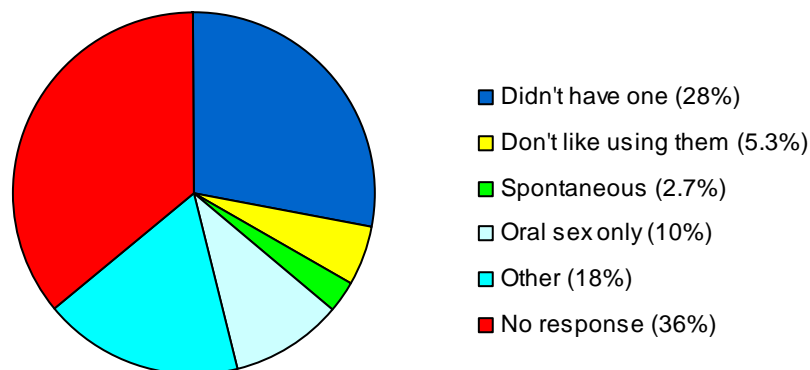


Table 2 - Burmese Migrant Characteristics (N=150)

Variable	%	(N)
Median Age: 34 years (IQR: 29-38 years)		
Gender		
Male	41.3	62
Female	58.7	88
Relationship Status		
Married	53.3	80
Separated	6.0	9
Divorced	6.7	10
Widowed	16.7	25
Regular Partner	8.0	12
Single	8.7	13
Other	0.6	1
Education		
Primary School	18.0	27
Some Primary School	14.0	21
Middle School	13.3	20
Some Middle School	18.7	28
High School	12.7	19
Some High School	0.7	1
University	4.6	7
Other	18.0	27
Year of Diagnosis		
1996-2001	3.4	5
2001-2005	33.5	50
2006-2009	63.1	94
No response = 1		
Location of HIV test		
Private Clinic	3.3	5
Public Hospital	8.7	13
Free Clinic	82.7	124
NGO	5.3	8
Reason for test		
Doctor recommended	69.3	46
Personal choice	28.7	43
Pregnancy	30.7	46
Other	16.0	24
Where do you receive HIV care?		
Free Clinic	72.0	108
Government hospital	9.3	14
International NGO	25.3	38
National NGO	2.0	3
Are you currently taking ART?		
Yes	39.3	59
No	60.7	91
Year of first arrival in Thailand		
1979-1989	6.0	9
1990-1995	15.3	23
1996-2000	16.0	24
2001-2005	34.7	52
2006-2008	28.0	42

Conclusions

According to our study results, most of the participants in this study are heterosexual. We have also found that self-reported illicit drug use is low. For these reasons, we can theorize that heterosexual contact is the main mode of HIV transmission among the displaced Burmese population living in Mae Sot, Thailand.

While most of the participants' primary intention of migrating into Thailand was to find a job, many said the main reason for migrating to Thailand was to get health care. Many participants did not know their HIV status while living in Burma and only learned of their infection through VCT services offered in Thailand.

Almost all of the participants are illegal immigrants and over two-thirds have been imprisoned at least once in Thailand. Illegal immigrant status makes accessing HIV care and support services difficult for already marginalized populations. It may also cause treatment interruption for those taking antiretroviral medications.

The large number of people who reported crossing the border more than once could be worrisome as migratory populations can potentially aid in the spread of the virus. This strengthens the argument that an infectious disease problem in one country is also a problem for neighboring countries. If effective HIV prevention programs cannot be implemented in Burma and in Thailand HIV infections will continue to rise in both countries.

A number of participants, who are at risk of deportation and incarceration, responded that, despite their instability, they felt safe living in Thailand. In contrast to safety issues, most of the participants answered that their life quality is poor. The median overall stigma score was low illustrating that displaced Burmese living with HIV are suffering from severe HIV/AIDS related stigma in the community. High stigma makes HIV prevention programs difficult to implement.⁽⁴²⁾

Food security was also identified as a major problem for participants. Food insecurity and malnutrition can have negative impact on their health and therefore should be addressed through and HIV lens.

It is difficult to measure sexual behavior among displaced Burmese living with HIV/AIDS in Thailand. Symptoms suggestive of STI are high among displaced Burmese living with HIV/AIDS, but we could not confirm the diagnosis nor get accurate medical records. We can only conclude that only one-third of those with STI symptom sought medical care. More STI care and management program should be implemented to prevent HIV transmission among displaced Burmese. At the very least, effective STI syndromic management services should be readily available for displaced Burmese living in Thailand. More positive prevention programs are needed among to encourage people to practice safer sex. Only HIV positive community can make a difference in this area. It is also necessary to make condoms more readily available at different locations in the community.

In conclusion, heterosexual contact remains the main mode of HIV transmission on the Thai-Burma border. Displaced Burmese living with HIV/AIDS in Thailand are encountering insufficient HIV care and high HIV/AIDS related stigma. They perceive their life quality as lower than normal and they struggle with have food security issues. They know well about transmission of HIV but they cannot practice safer sex due to limited access to condoms. Symptoms suggestive of STI were common among the people interviewed, but treatment of the symptoms is difficult. More research is needed to learn about STI problems among displaced Burmese and there is urgent need for effective STI services in this vulnerable community.

“HOW SHOULD WE HELP DISPLACED BURMESE LIVING WITH HIV/AIDS?”

For Burmese people living in economic and political oppression in Burma, Thailand is often considered to be a land of opportunity. As a result, the migration of Burmese into neighboring Thailand is on the rise. Lack of sufficient health education programs and problems related to human trafficking make displaced Burmese people highly vulnerable to HIV infection. In addition, there is a shortage of HIV/AIDS care and support programs for Burmese migrants in Thailand. As a result, migrants with HIV/AIDS end up living and dying in distress. We need to implement programs to stop the cycle of distress encountered by displaced Burmese living with HIV/AIDS and to minimize the future HIV transmission among Burmese migrants in Thailand and improve their quality of life.

RECOMMENDATIONS

1. There needs to be a well-organized HIV prevention team and more HIV education programs available for migrant workers

HIV/AIDS is one of the most significant health problems affecting the Burmese migrant population in Thailand. Voluntary counseling for HIV and testing (VCT) services are carried out by The Mae Tao Clinic (MTC) and Medecins Sans Frontieres (MSF) for migrant workers who have active Tuberculosis and Aide Medicale Internationale (AMI) for refugee population living in camps. VCT services at the MTC alone have found more than 250 new HIV positive cases annually for more than five years. This is only the tip of the iceberg; only small portions of the migrant population who request a HIV test receive a blood test for HIV.

The Thai government HIV prevention programs do not cover the displaced Burmese population in Thailand. As a result, HIV continues to be transmitted among displaced Burmese people living in Thailand. It is clear that more and more HIV prevention efforts need to be implemented on the Thai- Burma border for this vulnerable population. Currently, there are HIV prevention and education teams at MTC, World Vision Foundation of Thailand (WV) and the Migrant Assistance Program (MAP) foundation. It would greatly increase the effectiveness of HIV prevention efforts targeting migrant communities if all HIV prevention and education teams collaborated more frequently. In addition, prevention work carried out by displaced Burmese living with HIV/AIDS should be incorporated into a single team. This positive prevention team should include HIV positive displaced Burmese from different strata, for example, representatives of commercial sex workers and men who have sex with men (MSM).

Using the Royal Thai government HIV education model, it will be beneficial if displaced Burmese living with HIV were able to more actively participate in HIV prevention work. It is generally accepted that a HIV positive person can do HIV prevention work more effectively.^[18] They can give health talks about HIV and share personal stories about becoming infected with HIV at factories and migrant schools. Telling real life stories is more effective than poster campaigns.^[3] HIV positive displaced Burmese are unique population who need care and who can prevent further transmission of HIV among displaced Burmese community in Thailand.^[50] The general public would then be more aware of the risk factors for HIV infection by listening to how people became infected with HIV. There would also be more attention paid to the risk of HIV infection by the general Burmese migrant population in Thailand. It is important to understand that educators living with HIV may suffer a higher level of discrimination and stigma by the general migrant community due to their participation in prevention activities.

There needs to be more HIV/AIDS education programs for young Burmese migrants. Sexual and reproductive health knowledge of adolescent Burmese in the migrant community is important for effective HIV prevention within this community. There should be programs to improve the health and well-being of young people by promoting awareness, knowledge and recognition of adolescent sexual and reproductive health and rights among migrant communities in Thailand. Currently, the Adolescent Reproductive Health Networking (ARHN) on the Thai-Burma border develops youth centers and conducts training sessions for adult mentors in Thailand for displaced Burmese. We need to encourage the continuation of such programs.

2. There needs to be a HIV/AIDS care centre for displaced Burmese living with HIV/AIDS in Thailand

The most serious problem encountered by displaced Burmese living with HIV/AIDS in Thailand is that at the time they become sick; there is no one to care for them. They cannot go back to Burma due to social stigmatization, lack of financial resources, the deficient medical care system and lack of support by their relatives. As a result, terminally ill displaced Burmese with HIV/AIDS are living and dying on the streets of Thailand. After they die, local community-based organizations are left to organize their funerals with limited resources.

With the upcoming discontinuation of the activities of Medecins Sans Frontieres (MSF) along the Thai-Burma border, which currently provide effective clinical care and support for displaced Burmese with TB/HIV, there is an immediate demand for a health centre for the treatment of displaced Burmese living with HIV. In addition to MSF, the Thailand Government run Mae Sot hospital and the community-based Mae Tao Clinic (MTC) provide clinical care for terminally ill displaced Burmese with AIDS on the Thai-Burma border.

The Thailand Government's Mae Sot hospital admits only patients with legal working documents. Sadly, less than 2% of the displaced Burmese population living in Thailand has legal working documents. For displaced Burmese living with HIV/AIDS, Mae Sot hospital provides free ARV medication, CD4 count tests and viral load testing for HIV. Apart from those laboratory services, all other services which include palliative and Opportunistic Infections (OIs) medications, hospital stays, all other blood tests and investigations, professional fees need to be paid for by patients.

HIV/AIDS is chronic in nature and displaced Burmese with AIDS have to stay and receive treatment at Mae Sot hospital for long periods of time. Displaced Burmese living with HIV/AIDS cannot afford these medical fees and as a result the MTC covers all of these expenses. This places a heavy burden on this community-based clinic, as some HIV/AIDS cases cost more than 100,000 Baht (About 3,500 CAD) per patient for hospital care.

With Medecins Sans Frontieres (MSF) pulling out from the border, the Mae Tao Clinic will be the only health care centre providing care and support for displaced Burmese people infected with HIV/AIDS in Thailand. The Mae Tao Clinic (MTC) admits terminal AIDS patients and provides treatment as much as possible on the Thai-Burma border, however there are a lot of limitations, for example, there is no permanently appointed physician for treating AIDS cases and unskilled medics are left to provide care for terminally ill patients with AIDS. It will be beneficial for displaced Burmese people with HIV in Thailand, if an international NGO can provide support to existing clinical care services at the MTC.

An expert Burmese HIV/AIDS physician can be hired to work on the Thai-Burma border. Existing nurses and Home Based Care Teams (HIV positive team) can be upgraded and trained to be able to provide effective and efficient terminal care for displaced Burmese living with AIDS. Necessary laboratory tests could be carried out at Mae Sot General hospital.

If there is an appointed physician for displaced Burmese living with HIV/AIDS, STI can be treated properly, which will dramatically reduced HIV transmission among displaced Burmese living in Thailand. STI treatment services should readily available to general migrant community in Thailand. Having a HIV care center is crucial to carry out these functions.

If an international organization can implement a clinical care program for displaced Burmese people living with HIV/AIDS, all HIV/AIDS clinic care and treatment principles would then be in accordance with the treatment guidelines set by the Thai Ministry of Health. Moreover, no international organization should provide Anti Retro Viral (ARV) medications for those displaced Burmese living with HIV/AIDS. Since providing ARV medications for HIV infection is long-term in nature, if an international organization provides ARV for displaced Burmese, there will be the question: for how many years will they be able to provide ARV for displaced Burmese migrants? When there is no more funding, displaced Burmese living with HIV who are getting ARV will have a problem as their supply of medications would stop. Therefore in regards to supplying ARV, it is better for international organizations to advocate for the provision of ARV and to negotiate with the Thailand ministry of health to get a regular supply of ARV from the Thailand Ministry of Health.

The Thai health authorities complain that there are drug adherence issues for displaced Burmese with HIV, due to the mobility of this vulnerable population. If Home Base Care Teams are well be trained and empowered, the teams can handle this problem effectively. The teams can follow up with displaced Burmese with HIV who are on ARV and coordinate with them so that they have a regular supply of ARV.

3. Existing Home-Based-Care Team should be empowered

The Mae Tao clinic has organized a home based care team, of which all members are HIV positives. However, the team cannot perform HIV/AIDS care and prevention works effectively due to a lack of skills, funding and empowerment. There should be efficient and well-organized Home Based Care Teams for people living with HIV/AIDS. At the very least, every home based care team member should have a legal working permit to be able to avoid police harassment when providing care. The team also should include Thai people who are living with HIV/AIDS, to facilitate communication and the development of a more positive relationship with Thai authorities.

The team should perform three main tasks;

- (1). Provide care for sick displaced Burmese people living with HIV/AIDS
- (2). Follow up on adherence for migrants taking ARV
- (3). HIV prevention work among the general displaced Burmese population

4. There needs to be an income generation program for displaced Burmese living with HIV/AIDS in Thailand

Displaced Burmese migrants in Thailand encounter economic hardship due to exploitation, language barriers and social constraints. Socioeconomic problems already encountered by illegal migrants in Thailand are compounded by the HIV/AIDS related stigma and discrimination. There needs to be income generation programs for displaced Burmese migrants living with HIV in Thailand to alleviate their day to day economic hardship. Certain community-based organizations on the Thai-Burma border, like Social Action for Women (SAW) have implemented income generation programs for displaced Burmese women.

Social Action for Women (SAW) was founded to assist displaced women from Burma who are in crisis situations after having fled to Mae Sot, Thailand. SAW is based in Mae Sot and was established to support women facing difficulties through the provision of shelter, health education, rights awareness, counseling and vocational training for unskilled women. There

should be some income generation programs for displaced Burmese which are affiliated with existing income generation programs on the Thai-Burma border.

Feasible and sustainable income generation programs include sewing factories, post-card production and soap production. There are 54 migrant schools for Burmese children, so, there is a large demand for school uniforms on the Thai-Burma border. In addition, there is market demand for soap for Burmese migrants and refugees. Post-cards and souvenir production is also an option. These domestic hand made products can be distributed both locally and internationally. These income generation programs may help to relieve the day to day economic hardship encountered by the displaced Burmese living with HIV/AIDS and their families.

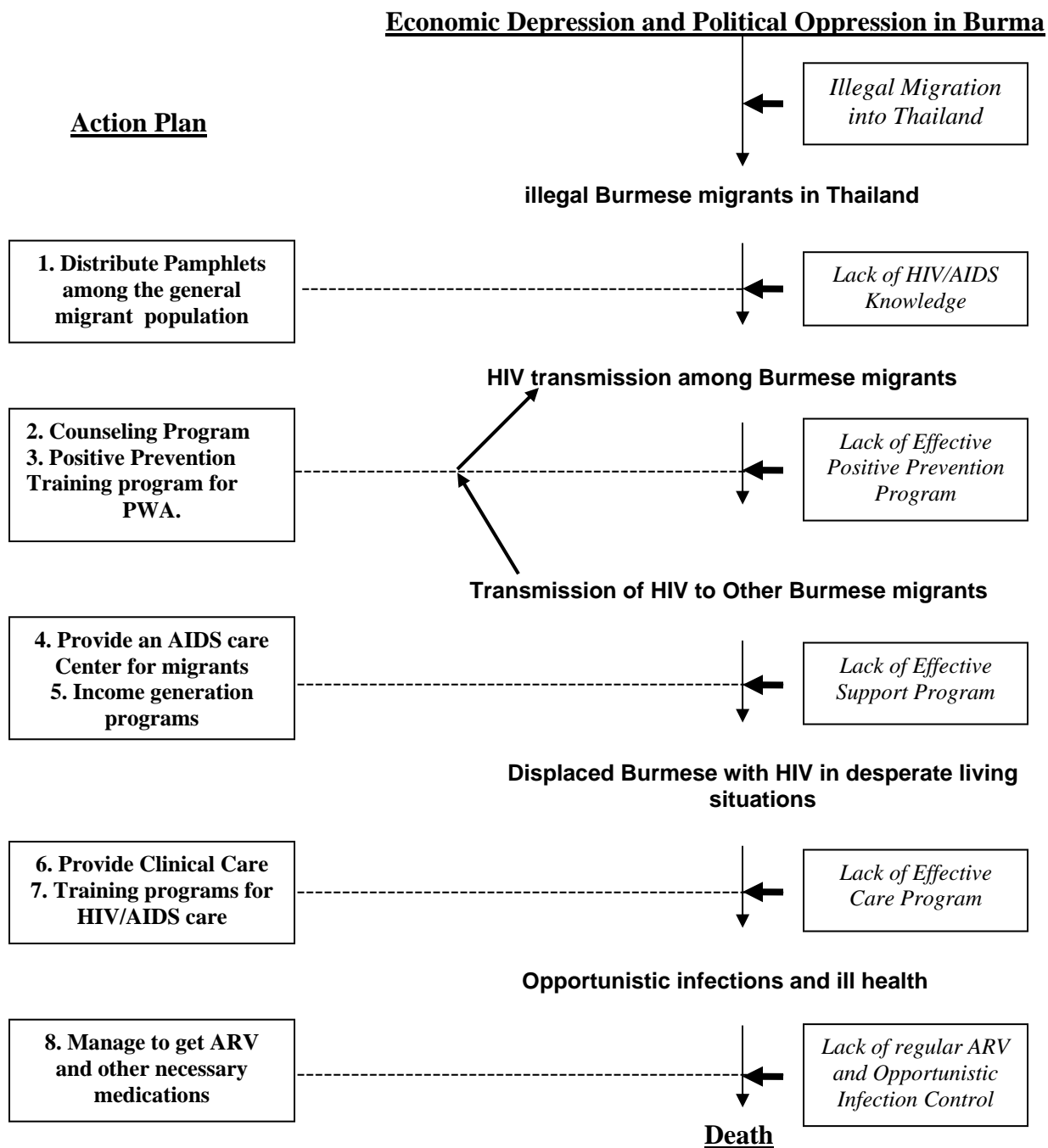


Diagram 1 - Proposed Action Plan For Displaced Burmese Living With HIV/AIDS

APPENDICES

CONSENT FORM

Assessment of health related quality of life in displaced Burmese living with HIV/AIDS

Letter of Consent

I, _____ understand explanations of _____ about health related quality of life assessment interview for displaced persons living with HIV/AIDS, and its purposes. I know that my personal identity will be protected and information collected from this interview will be stored in a locked cabinet at Mae Tao Clinic, and only the researchers will have access to it. After five years, all this information will be destroyed.

I also know to whom I should contact, if I have any further questions concerning this interview. I know that there may be unusual or unpredictable circumstances in which the Myanmar administration may be aware of my participation. I have considered that risk before participation.

My participation in this study is completely voluntary. I understand that there is no penalty for not participating and I have a right to withdraw from the study, or interview at any time.

I agree to take part in this study by signing this consent form.

Participant:

Name _____

Signature _____

Counselor/Interviewer:

Name _____

Signature _____

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Notification of Application Status

APPROVED

By Hal Weinberg at 3:22 pm, Jun 27, 2008

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Risk	Minimal
Approval Status	Pending REB (Blue)
Approval Date	June 27, 2008
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REB Date	00/00/00

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Approved Subject To Ethics Approval	Yes
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Date Granting Agency Approval Began	March 27, 2008
Date Grant Ends	March 27, 2009

Amendment Date 00/00/00

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMI	Aide Medicale Internationale
ARC	American Refugee Committee
ARHN	Adolescent Reproductive Health Networking
ART / ARV	Anti Retroviral Therapy
ASEAN	Association of Southeast Asian Nations
AZT	Zidovudine
BCC	Behavioral Change Communication
BCCfE	British Columbia Centre for Excellence in HIV/AIDS
BCPWA	British Columbia Persons With AIDS Society
CATIE	Canadian AIDS Treatment Information Exchange
CBO	Community-based organization
CSW	Commercial Sex Worker
DOT	Directly Observed Therapy
FHS	Faculty of Health Sciences
GF	Global Fund
GDP	Gross Domestic Product
GPO	Government Pharmaceutical Organization
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HR-QoL	Health Related Quality of Life
IDRC	International Development Research Centre
ILO	International Labor Organization
INGO	International nongovernmental organization
IOM	International Organization for Migration
IQR	Interquartile range
IRC	International Red Cross / International Rescue Committee
KAP	Knowledge, Attitude and Practice
MAP	Migrant Assistance Program
MDG	UN Millennium Development Goal
MDRTB	Multi Drug Resistant Tuberculosis
MOPH	Ministry of Public Health
MPH	Master in Public Health
MSF	Medecins Sans Frontieres
MSGH	Mae Sot General Hospital
MSM	Men who have sex with men

MTC	Mae Tao Clinic
NAAPHA	National Access to Antiretroviral Program for People living with HIV/AIDS
NGO	Nongovernmental Organization
NHEC	National Health and Education Committee
PHAMIT	Prevention of HIV/AIDS Among Migrant Workers in Thailand
PHOMS	Perinatal HIV Outcome Monitoring System
PMTCT	Prevention of Mother to Child Transmission
PWA	Persons Living with HIV/AIDS
SAW	Social Action for Women
SFU	Simon Fraser University
SMRU	Shoklo Malaria Research Unit
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNICEF	United Nations Children's Emergency Fund
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling for HIV and Testing
WHO	World Health Organization
WHOQOL HIV	World Health Organization, HIV/AIDS Quality of Life
WV	World Vision Foundation of Thailand

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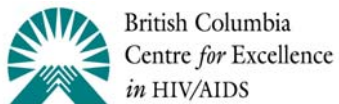
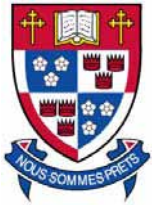
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“Governments are acting on their promises at the 2006 United Nations High Level Meeting on HIV/AIDS, to scale up towards universal access to HIV prevention, treatment, care, and support by 2010.”

Dr. Peter Piot, UNAIDS Executive Director^[56]



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